

August 2010

**MEDICAID
MANAGED CARE**

**CMS's Oversight of
States' Rate Setting
Needs Improvement**



GAO

Accountability * Integrity * Reliability



Highlights of [GAO-10-810](#), a report to Committee on Finance, U.S. Senate, and Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid managed care rates are required to be actuarially sound. A state is required to submit its rate-setting methodology, including a description of the data used, to the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) for approval. The Children's Health Insurance Program Reauthorization Act of 2009 required GAO to examine the extent to which states' rates are actuarially sound. GAO assessed CMS oversight of states' compliance with the actuarial soundness requirements and efforts to ensure the quality of data used to set rates. GAO reviewed documents, including rate-setting review files, from 6 of CMS's 10 regional offices. The selected offices oversaw 26 of the 34 states with comprehensive managed care programs; the states' programs varied in size and accounted for over 85 percent of managed care enrollment. GAO interviewed CMS officials and Medicaid officials from 11 states that were chosen based in part on variation in program size and geography.

What GAO Recommends

GAO recommends that CMS implement a mechanism to track state compliance with the requirements, clarify guidance on rate-setting reviews, and make use of information on data quality in overseeing states' rate setting. HHS agreed with our recommendations and described initiatives underway that are aimed at improving CMS's oversight.

[View GAO-10-810 or key components.](#)
For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

MEDICAID MANAGED CARE

CMS's Oversight of States' Rate Setting Needs Improvement

What GAO Found

CMS has been inconsistent in reviewing states' rate setting for compliance with the Medicaid managed care actuarial soundness requirements, which specify that rates must be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries. Variation in CMS regional office practices contributed to this inconsistency in oversight. For example, GAO found significant gaps in CMS's oversight of two states.

- First, the agency had not reviewed Tennessee's rate setting for multiple years and only determined that the state was not in compliance with the requirements through the course of GAO's work. According to CMS officials, Tennessee received approximately \$5 billion a year in federal funds for rates that GAO determined had not been certified by an actuary, which is a regulatory requirement.
- Second, CMS had not completed a full review of Nebraska's rate setting since the actuarial soundness requirements became effective, and therefore may have provided federal funds for rates that were not in compliance with all of the requirements.

Variation in a number of CMS regional office practices contributed to these gaps and other inconsistencies in the agency's oversight of states' rate setting. For example, regional offices varied in the extent to which they tracked state compliance with the actuarial soundness requirements, their interpretations of how extensive a review of a state's rate setting was needed, and their determinations regarding sufficient evidence for meeting the actuarial soundness requirements. As a result of our review, CMS took a number of steps that may address some of the variation that contributed to inconsistent oversight, such as requiring regional office officials to use a detailed checklist when reviewing states' rate setting. However, additional steps are necessary to prevent further gaps in oversight and additional federal funds from being paid for rates that are not in compliance with the actuarial soundness requirements.

CMS's efforts to ensure the quality of the data used to set rates were generally limited to requiring assurances from states and health plans—efforts that did not provide the agency with enough information to ensure the quality of the data used. CMS's regulations do not include standards for the type, amount, or age of the data used to set rates, and states are not required to report to CMS on the quality of the data. When reviewing states' descriptions of the data used to set rates, CMS officials focused primarily on the appropriateness of the data rather than their reliability. With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending. States and other sources have information on the quality of data used for rate setting—information that CMS could obtain. In addition, CMS could conduct or require periodic audits of data used to set rates; CMS is required to conduct such audits for the Medicare managed care program.

Contents

Letter		1
	Background	4
	CMS's Oversight of States' Compliance with Actuarial Soundness Requirements Has Been Inconsistent, in Part Due to Variation in Regional Office Practices	9
	CMS's Limited Efforts Do Not Ensure the Quality of the Data Used to Set Rates	15
	Conclusions	18
	Recommendations for Executive Action	19
	Agency Comments and Our Evaluation	20
Appendix I	Methodology for Selecting CMS Regional Offices and Analyzing CMS's Medicaid Managed Care Rate-Setting Files	22
Appendix II	Methodology for Selecting States to Contact	27
Appendix III	Selected States' Reported Efforts Intended to Ensure the Quality of the Data Used to Set Rates	28
Appendix IV	Comments from the Department of Health and Human Services	29
Appendix V	GAO Contact and Staff Acknowledgments	34
Tables		
	Table 1: Summary of the Regulatory Requirements Covered in CMS's Checklist for Reviewing Medicaid Managed Care Rate Setting	7
	Table 2: Extent to which Evidence Was Cited in the 28 CMS Files We Reviewed	12
	Table 3: CMS Regional Offices Reviewed	22

Table 4: Description of the 28 CMS Medicaid Managed Care Rate-Setting Files Reviewed	24
Table 5: Information about the Medicaid Managed Care Programs of Selected States, as of 2008	27
Table 6: Eleven States' Reported Efforts Intended to Ensure the Quality of Data Used to Set Medicaid Managed Care Rates	28

Abbreviations

ASOP	Actuarial Standard of Practice
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HHS	Department of Health and Human Services
OACT	Office of the Actuary
PCCM	primary care case management
PERM	Payment Error Rate Measurement
PPACA	Patient Protection and Affordable Care Act

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



United States Government Accountability Office
Washington, DC 20548

August 4, 2010

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

The Honorable Henry A. Waxman
Chairman
The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

The importance of managed care in the Medicaid program is significant, with nearly half of all Medicaid enrollees—approximately 20.7 million individuals—enrolled in capitated managed care in 2008 and a total of over \$62 billion in federal and state spending for managed care in 2007.¹ Moreover, Medicaid—a joint federal-state program that finances health care for certain categories of low-income individuals—is expanding. With the passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010, states will expand coverage under the Medicaid program to an estimated 18 million additional people.² Expansions of Medicaid are likely to increase the number of people enrolled in and amount of spending for managed care, making effective federal oversight of this large and complex component of the Medicaid program particularly critical.

¹Data on Medicaid managed care spending were not available for 2008.

²Pub. L. No. 111-148, 124 Stat. 119, tit. II, subtit. A, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, tit. I, subtit. C. Beginning in 2014, or sooner at a state's option, all citizens and certain legal residents with incomes at or below 133 percent of the federal poverty level (\$14,404 for an individual or \$29,327 for a family of four in 2010) and who are under 65 and not already required to be covered under Medicaid will be eligible. See Pub. L. No. 111-148, § 2001(a)(1), as amended by § 10201. CMS's Office of the Actuary (OACT) estimated that this will result in 18 million individuals receiving primary coverage and 2 million individuals receiving supplemental coverage through Medicaid.

The potential benefits and risks of Medicaid managed care are substantial. Managed care is designed to ensure the provision of appropriate health care services in a cost-efficient manner. However, capitation payments, which are made prospectively to health plans to provide or arrange for services for Medicaid enrollees,³ can create an incentive to underserve or deny access to needed care.⁴ Thus, appropriate safeguards are needed to ensure access to care and appropriate payment in Medicaid managed care. One such safeguard included in federal law is the requirement that states' capitation rates be actuarially sound.⁵ In 2002, the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees states' Medicaid programs, issued regulations defining actuarially sound rates as those that are (1) developed in accordance with generally accepted actuarial principles and practices; (2) appropriate for the populations to be covered and the services to be furnished; and (3) certified as meeting applicable regulatory requirements by qualified actuaries.⁶ The regulations also specify the documentation states are required to submit to CMS regional offices to demonstrate compliance with the requirements, including a description of their rate-setting methodology and the data used to set rates. In 2003, CMS finalized a detailed checklist that its regional office staff could use in their reviews of states' rate setting and for states and states' actuaries to consider in setting rates.⁷

³Throughout this report, the term "managed care" refers only to capitated managed care arrangements. States may also have primary care case management (PCCM) programs under which a primary care provider is paid a nominal monthly, per person, case management fee to coordinate care for beneficiaries, in addition to fee-for-service (FFS) reimbursement for any health care services they provide. While some consider PCCM programs to be managed care, we consider those programs to be FFS-based arrangements because participating providers are predominately paid on a FFS basis.

⁴Incentives regarding the provision of services can exist under both capitated and FFS payment systems. Under capitated payment systems, health plans and, in some cases, providers can profit from not delivering services for which they have already received payment. In contrast, beneficiaries in FFS systems may be at risk for the overprovision of services as providers seek to increase revenue. However, if FFS payment levels are too low, physicians may underserve their patients or be unwilling to participate at all.

⁵See Social Security Act §1903(m)(2)(A).

⁶See 42 CFR §438.6(c)(1)(i)(2009).

⁷In this report, we refer to capitation rate setting for Medicaid managed care as "rate setting" and managed care capitation rates as "rates."

The Children's Health Insurance Program Reauthorization Act of 2009 directed us to examine the extent to which state Medicaid managed care payment rates are actuarially sound.⁸ Specifically, we assessed (1) CMS's oversight of states' compliance with the Medicaid managed care actuarial soundness requirements, and (2) CMS's efforts to ensure the quality of the data used to set rates.

To assess CMS's oversight of states' compliance with the actuarial soundness requirements, we reviewed documentation of CMS's oversight efforts from 6 of the 10 CMS regional offices. These offices were responsible for reviewing rate setting and approving rates for 26 of the 34 states with comprehensive managed care programs, were geographically diverse, and oversaw states with programs that ranged in size and accounted for about 85 percent of national managed care enrollment.⁹ Our review of CMS's oversight efforts included completing a structured review of 28 CMS files documenting rate-setting reviews completed as of October 31, 2009.¹⁰ (See app. I for a summary of the criteria we used to select the 6 CMS regional offices and the methodology for our review of CMS files.) To supplement our review, we interviewed officials in CMS's central office and the 6 selected CMS regional offices to obtain information regarding steps taken by CMS to ensure the actuarial soundness of rates; and we reviewed regional office standard operating procedures. We also interviewed Medicaid officials from 11 of the states overseen by the 6 selected CMS regional offices to obtain their views of, and experiences with, CMS's oversight of state compliance with the actuarial soundness requirements.¹¹ These states were geographically

⁸See Pub. L. No. 111-3, §617, 123 Stat. 8, 103.

⁹The CMS regional offices selected were the offices located in Atlanta, Chicago, Kansas City, New York City, Philadelphia, and San Francisco. We limited our review to CMS's oversight of rate setting for comprehensive managed care programs that involve risk contracts, i.e., contracts under which the health plan assumes risk for the cost of providing services. In addition to managed care programs that provide comprehensive services, some states have also implemented managed care for targeted categories of services. These include programs such as prepaid ambulatory health plans that provide a limited range of services and coverage. These programs were not included in the scope of our work.

¹⁰Several states overseen by the selected CMS regional offices have multiple comprehensive managed care programs that have separate rate-setting processes, each of which is subject to CMS review. Thus, for some states, we reviewed more than one CMS rate-setting review file.

¹¹The 11 states were Arizona, California, Florida, Indiana, Maryland, Nebraska, New Jersey, New York, Pennsylvania, South Carolina, and Tennessee. In some of our interviews, the state included members of the state-contracted actuarial firm in the conversation.

diverse and had managed care programs that varied in size. (See app. II for our criteria for selecting states for interviews.)

To assess CMS's efforts to ensure the quality of data used to set rates, we reviewed CMS policies and guidance related to rate setting. In addition, in interviews with officials from CMS's central office and the selected regional offices, we asked about steps CMS takes to ensure data quality, including what information CMS requires states to include in their rate-setting submissions to demonstrate the appropriateness and reliability of the data used to set rates and whether any audits or studies of rate setting had been performed. We also assessed, as part of our review of CMS files, the information provided in states' rate-setting submissions about steps taken to ensure data quality, including statements made by states' actuaries. In interviews with state Medicaid officials, we asked about their processes to ensure data quality and their experiences with CMS oversight of data quality. We also reviewed relevant audit findings from the Washington State Auditor's Office.¹² Finally, we contacted officials from five health plans to discuss their efforts to ensure the quality of the data submitted to states for rate setting.¹³

We conducted our performance audit from October 2009 through July 2010 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

Under Medicaid managed care, states contract with health plans and prospectively pay the plans a fixed monthly rate per enrollee to provide or arrange for most health services. These contracts are known as "risk" contracts because plans assume the risk for the cost of providing covered services. States' processes for developing rates may vary in a number of ways, including the type and time frames of data they use as the basis for

¹²We contacted all of the state auditor's offices describing the scope of our work and asking whether they had completed any related studies. The Washington State Auditor's Office was the only office that reported having completed related work.

¹³The health plans contacted varied in size, whether they served only Medicaid clients, and whether they were nonprofit.

setting rates, referred to as the base-year data,¹⁴ and what approach they use to negotiate rates with health plans. After rates are developed, an actuary certifies the rates as actuarially sound for a defined period of time, typically 1 year. In order to receive federal funds for its managed care program, a state is required to submit its rate-setting methodology and rates to CMS for review and approval. This review, completed by CMS regional office staff, is designed to ensure a state complies with federal regulatory requirements for setting actuarially sound rates.

CMS's Oversight of Rate Setting

CMS published a final rule on June 14, 2002, outlining the agency's regulatory requirements for actuarially sound rates. These requirements largely focus on the process states must use in setting rates.¹⁵ For example, the regulations require states to document their rate-setting methodology and include an actuarial certification of rates. In addition, the regulations include a requirement that when states use data from health plans as the basis for rates they must have plan executives certify the accuracy and completeness of their data. The regulations do not include standards for the type, amount, or age of the data that states may use in setting rates. The regulations also do not include standards for the reasonableness or adequacy of rates. In the preamble to the final rule, CMS noted that health plans were better able to determine the reasonableness and adequacy of rates when deciding whether to contract with a state.

In July 2003, CMS finalized a detailed checklist that regional office staff could use when reviewing states' rate-setting submissions for compliance with the actuarial soundness requirements and that states and states' actuaries could use when developing rates.¹⁶ The checklist includes

¹⁴Base-year data may include FFS claims data, encounter data, or health plan financial data. FFS claims data are the record of services provided to recipients in the FFS program and the cost of those services. Provided by health plans, encounter data are the primary record of, and include detailed information on, services provided to Medicaid beneficiaries enrolled in capitated managed care. Health plan financial data may include aggregate spending by category of service, but do not include information on individual encounters or claims.

¹⁵See 42 CFR §438.6(c)(2). The regulations included in the final rule were effective on August 13, 2002, and states had until June 16, 2003, to bring their managed care programs into compliance.

¹⁶A CMS workgroup developed the checklist, which was finalized July 22, 2003. Prior to the July 2003 checklist, officials used a number of different tools when reviewing rate setting for compliance with the actuarial soundness requirements.

citations to, and a description of, each regulatory requirement; guidance on what constitutes state compliance with the requirement; and spaces for the CMS official to check whether each requirement was met and cite evidence from the state's submission for compliance with the requirement. The checklist also provides guidance on the level of review that should occur for different types of rate changes. When the state is developing a new rate, or using new actuarial techniques or data to change previously approved rates, the checklist indicates a full review should be done, which entails reviewing the state's submission for compliance with all of the requirements covered in the checklist. For adjustments to rates that were previously approved as meeting the regulations,¹⁷ the checklist indicates a partial review should be done; a partial review focuses on a few key requirements in the checklist, such as ensuring that the state has included a certification of rates from a qualified actuary. As of June 2010, CMS was in the process of revising the checklist. One of the planned changes was to emphasize the need for more complete encounter data because CMS officials indicated that the agency has determined that encounter data that do not include pricing information are not sufficient for setting rates. CMS expects to complete the checklist revisions by November 2010. (See table 1 for a summary of the sections in CMS's checklist.)

¹⁷For example, a state may adjust its rates to reflect a midyear program change, such as adding a service to the program's list of covered benefits, or a state may use an inflation factor to adjust rates from a prior year.

Table 1: Summary of the Regulatory Requirements Covered in CMS’s Checklist for Reviewing Medicaid Managed Care Rate Setting

Section of the checklist	Description of key requirements
Overview of rate-setting methodology ^a	<p>State is required to provide documentation regarding the general rate-setting methodology, contract procurement, and the actuarial certification, including:</p> <ul style="list-style-type: none"> • the rates and the time period for the rates, • a description of risk-sharing mechanisms, • a projection of expenditures, and • an explanation of rate setting.
Base year utilization and cost data ^b	<p>State is required to provide documentation and an assurance that all payment rates are:</p> <ul style="list-style-type: none"> • based only upon services covered under the state Medicaid plan or costs related to providing these services, such as health plan administration;^c and • provided under the contract to Medicaid-eligible individuals.
Adjustments to base year data ^d	<p>State is required to provide documentation of any adjustments to the base year data, including detailing the policy assumptions, size, and effect of the adjustments. Adjustments may include changes to the following:</p> <ul style="list-style-type: none"> • services covered, • administration, • medical service cost and trend inflation, and • utilization.
Rate category groupings ^b	<p>State is required to create rate cells specific to the enrolled population. Categories the state should normally consider in the establishment of rates include age, gender, locality/region, and eligibility. States may omit categories or combine them with another category.</p>
Other sections ^b	<p>State is required to document their methodology in a number of other areas. For example:</p> <ul style="list-style-type: none"> • document that they have examined base year data for distortions, such as special populations with catastrophic costs, and adjusted rates in a cost-neutral manner; • document the use of reinsurance and other risk-sharing mechanisms; and • explain any incentive arrangements in the contract.

Source: GAO analysis of CMS checklist.

Notes:

^aThis section of the checklist is addressed in both full and partial rate-setting reviews.

^bThis section of the checklist is addressed in a full rate-setting review, but not in a partial review.

^cState Medicaid plans are approved by CMS and define how each state will operate its Medicaid program, including which populations and services are covered.

^dThis section of the checklist is addressed in a full rate-setting review and may be covered in a partial review for adjustments that the state made that had not previously been subject to CMS review.

According to CMS officials, the regional officials responsible for conducting rate-setting reviews may have a financial background, but are not actuaries. Officials also noted that CMS’s OACT, which provides actuarial advice to other offices within CMS, is generally not involved with Medicaid rate-setting reviews. However, they indicated that when the CMS officials responsible for rate-setting reviews have concerns with a state’s

rate-setting methodology and cannot resolve those concerns with the state, they can contact OACT to request an independent review.

Actuarial Principles and Practices for Medicaid Managed Care Rate Setting

CMS's regulations require that actuarially sound rates be developed in accordance with generally accepted actuarial principles and practices. There is no Actuarial Standard of Practice (ASOP) that applies to actuarial work performed to comply with CMS's regulations. However, in 2005, the American Academy of Actuaries published a practice note that provides nonbinding guidance on certifying Medicaid managed care rates.¹⁸

The practice note includes a proposed definition for "actuarial soundness," as there was no other working definition of the term that would be relevant to the actuary's role in certifying Medicaid managed care rates. Under the definition, rates are actuarially sound if, for the period of time covered by the certification, projected premiums provide for all "reasonable, appropriate, and attainable costs;" also under the definition, rates do not have to encompass all possible costs that any health plan might incur. The note emphasizes that the definition only applies to the certification of Medicaid managed care rates, and that it differs from the definition used when certifying a health plan's rates.

The practice note also provides information on the actuary's role in assessing the quality of data used to set rates and refers the actuary to the ASOP on data quality for further guidance.¹⁹ The practice note explains that if the actuary is involved in developing the rate, then the actuary would consider all available data, including FFS data, Medicaid managed care encounter data, and Medicaid managed care financial reports and financial statements. The actuary would typically compare data sources for reasonableness and check for material differences when determining the preferred source or sources for the base-year data. The ASOP on data quality clarifies that while actuaries should generally review the data for reasonableness and consistency they are not required to audit the data.

¹⁸ ASOPs and practice notes do not have the same standing in determining what constitutes generally accepted actuarial principles and practices. ASOPs are considered part of actuaries' professional code of conduct and have the highest standing. In contrast, practice notes are not a definitive statement as to what constitutes generally accepted practice.

¹⁹ The ASOP on data quality provides actuaries with guidance on selecting underlying data for an actuarial product, relying on data supplied by others, reviewing and using data, and making appropriate disclosures regarding data quality. ASOP No. 23, *Data Quality* (Doc. No. 097; December 2004).

The ASOP also explains that the accuracy and completeness of the data are the responsibility of those that provided them, namely the state or health plans.

CMS's Oversight of States' Compliance with Actuarial Soundness Requirements Has Been Inconsistent, in Part Due to Variation in Regional Office Practices

CMS has been inconsistent in its review of states' rate setting. In the six CMS regional offices we reviewed, CMS had not reviewed one state's rate setting for compliance with the actuarial soundness requirements and had not conducted a full review for another. We also identified a number of other inconsistencies in CMS's review of states' compliance with the actuarial soundness requirements. Variation in CMS regional offices' practices contributed to these inconsistencies in oversight.

CMS Has Been Inconsistent in Reviewing States' Rate Setting for Compliance with the Actuarial Soundness Requirements

In the six CMS regional offices we reviewed, we found inconsistencies in CMS's review of state's rate setting, including significant gaps in the agency's oversight of two states' compliance with the actuarial soundness requirements. First, CMS had not reviewed one state's (Tennessee) rate setting for compliance with the actuarial soundness requirements or approved the state's rates. In 2007, Tennessee began transitioning its managed care program, which included all of the state's approximately 1 million Medicaid enrollees, to risk contracts that were subject to the actuarial soundness requirements. Since moving to risk contracts, the state submitted at least two actuarial reports to CMS's Atlanta regional office indicating the program change, but these documents did not trigger a CMS review. These reports did not include actuarial certifications, and Tennessee officials confirmed that the state's rates had not been certified by an actuary, which is a regulatory requirement.²⁰ As a result, according to CMS officials, Tennessee received, and is continuing to receive, approximately \$5 billion a year in federal funds for rates that we determined had not been certified by an actuary or assessed by CMS for compliance with the requirements. Based on issues we raised during our review, CMS determined that Tennessee was not in compliance with the

²⁰State officials indicated that they hired an actuarial firm to produce the state's managed care rates, but the state did not have the firm provide an actuarial certification of the rates.

actuarial soundness requirements and, as of June 2010, was working to bring the state into compliance.²¹

Second, while CMS officials said that all states should have had a full review of rate setting after the actuarial soundness requirements became effective in August 2002, it appeared that CMS officials had not completed a full rate-setting review for Nebraska.²² CMS had no documentation of its last full review of Nebraska's rate setting, but officials believed that the last full review was completed in 2002.²³ According to Nebraska officials, the state last made significant changes to its rate setting for the state fiscal year beginning in 2001, which according to criteria in CMS's checklist would have triggered a full CMS review. Based on what CMS and Nebraska officials told us, CMS's last full review was likely done before the actuarial requirements became effective. As a result, Nebraska received federal funds for more than 7 years for rates that may not have been in compliance with all of the actuarial soundness requirements.

In addition to these gaps in oversight, we found inconsistencies in the reviews CMS completed. In instances when CMS did a full rate-setting review, it was unclear whether CMS consistently ensured that states met all of the actuarial soundness requirements. We found evidence that the rates in all 28 of the CMS files we reviewed were certified by a member of the American Academy of Actuaries, as is required by the regulations.²⁴ However, the extent to which CMS ensured state compliance with other aspects of the actuarial soundness requirements—such as the requirement that rates be based only on services covered under the state's Medicaid

²¹As of June 2010, CMS was in the process of reviewing Tennessee's rate setting for health plans participating in the state's managed long-term care program. These rates, which are effective August 1, 2010, were certified by an actuary.

²²As of 2008, the most recent year for which CMS data are available, about 33,000 individuals—or 16 percent of Nebraska's Medicaid population—were enrolled in comprehensive managed care.

²³A CMS official in the Kansas City regional office told us that the state submitted rates for review a number of times after 2002; however, those submissions did not trigger a full review by CMS. Rather, according to the regional official, CMS completed a number of partial reviews, which would have ensured that an actuary certified the rates but would not have assured compliance with other requirements.

²⁴The 28 CMS files that we reviewed did not include files related to Tennessee or Nebraska, because CMS had not reviewed Tennessee's rate setting for the most recent contract and had not completed a full review of Nebraska's rate setting since the actuarial soundness requirements became effective.

plan or costs related to providing these services—was unclear. For example, in nearly a third of the files we reviewed, or 8 of 28 files, CMS officials did not use the rate-setting checklist to document their review; therefore we could not determine whether CMS ensured that states were in compliance with all of the requirements. In 17 of the 20 remaining files where the CMS official used the checklist, the official cited evidence of the state’s compliance for some requirements, but not others.

When officials did cite evidence, the evidence did not always appear to meet the requirements. For example, one of the requirements in the regulations is that states provide an assurance that rates are based only on services covered under the state’s Medicaid plan or costs related to providing these services. Of the 19 files where CMS officials cited evidence of such an assurance, we were unable to locate the assurance in 2 of the files. Another requirement is that states include a comparison of expenditures under the previous year’s rates to those projected under the proposed rates. In the 15 files where CMS cited evidence of the comparison of expenditures, we did not find a comparison that appeared to meet the requirement in 2 of the files. See table 2 for more information on the extent to which evidence was cited in the CMS files we reviewed.

Table 2: Extent to which Evidence Was Cited in the 28 CMS Files We Reviewed

Actuarial soundness requirements covered in CMS's checklist	Number of files where CMS cited evidence:		
	Appeared to meet the requirement	Did not appear to meet the requirement	No evidence cited ^a
The state must include documentation of size and effect of adjustments to base year data for medical/trend inflation	19	0	9
The state must include documentation of size and effect of adjustments to base year data for administrative cost allowances	19	0	9
The state's documentation must include an assurance that capitation rates are based only on services covered under the state's Medicaid plan or costs related to providing these services	17	2	9
The state must document final capitation rates	14	3	11
The state's documentation must include an assurance that capitation rates are for Medicaid-eligible individuals	14	5	9
The state's documentation must include a comparison of expenditures under the previous year's contract to those projected under the proposed contract	13	2	13
The state must include documentation of size and effect of adjustments to the base year data for incomplete data	13	0	15 ^b
The state must include documentation of size and effect of adjustments to base year data for benefit differences	10	7	11 ^c

Source: GAO analysis of 28 CMS files.

Notes:

^aThis column includes 8 files where CMS officials did not use the checklist to document their review, as well as other files where the CMS official did not cite evidence for a particular actuarial soundness requirement.

^bIn 6 of these files, CMS did not cite evidence as the state did not make the specified adjustment and thus the requirement for documentation was not applicable.

^cIn 2 of these files, CMS did not cite evidence as the state did not make the specified adjustment and thus the requirement for documentation was not applicable.

Finally, CMS did not consistently review states' rate setting for compliance with the actuarial soundness requirements prior to the new rates being implemented. In 20 of 28 files we reviewed, we found that CMS completed its review of rate setting after the state had begun implementing the proposed rates; that is, after the effective date of the proposed rates. CMS officials told us that a variety of factors could delay the approval of rates, including states submitting a request for approval after implementing the rates. CMS officials further explained that they did not consider a state to be out of compliance with the actuarial soundness requirements until the end of the federal fiscal year quarter in which the state implemented the

unapproved rates.²⁵ Of the 20 files where CMS approved rates after the state implemented them, 13 had rates that were approved more than 3 months after the state implemented the rates, which means that the rates were approved after the end of the quarter in which they were implemented.²⁶ CMS officials confirmed that the agency generally continued to provide federal funds for the states' managed care contracts even in cases where the rates were not approved by the end of the quarter. According to CMS officials, if the state failed to gain CMS approval or had to lower the rates to achieve approval, then CMS would reduce future federal reimbursement to account for federal funds paid to states for rates that had not been approved. However, CMS reviewing states' rate setting after states have begun implementing rates may result in changes to states' rate-setting methodology; this could lead to retroactive changes, including reductions, in health plans' rates. The possibility of rates being decreased retroactively may make it difficult for health plans to assess the reasonableness and adequacy of rates when contracting with states, an assessment that CMS relies on as a check of states' rate setting.

Variation in Practices among CMS Regional Offices Contributed to Inconsistent Oversight

Variation in a number of regional office practices contributed to the inconsistency in CMS's oversight of states' rate setting. Regional offices varied in the extent to which they tracked state compliance with the requirements, the extent to which they withheld federal funds, their criteria for doing full and partial reviews of rate setting, and what they considered to be sufficient evidence for meeting the requirements.

- **Tracking compliance.** Officials from all of the regional offices we spoke with told us that they tracked basic information regarding the status of the CMS review process, such as when a state's submission was received and when CMS's approval letter was issued. However, based on our interviews with CMS regional officials, we found that four of the six regional offices did not track information that would allow them to identify states that were not in compliance with actuarial soundness requirements, such as the beginning and end dates of the rates specified by the actuary in the certification. Officials from the remaining two regional offices, Kansas City

²⁵For example, if a state were to start paying rates in October, the beginning of the first quarter of the federal fiscal year, then, according to CMS officials, its rates would need to be approved by the end of December to be in compliance with the actuarial soundness requirements.

²⁶Of the 13 files, 8 showed evidence of CMS approving rates more than 6 months after state implementation, with 3 of those indicating CMS approval more than 9 months later.

and San Francisco, told us they tracked the effective dates of approved rates.

- **Withholding funds.** There was also variation among regional offices in the conditions that had to be met in order for states to receive federal funds. For example, officials from the San Francisco regional office told us that they did not release federal funds to states until the states' managed care contract and rates had been approved. Officials said that the office had withheld funds in several cases until the state demonstrated compliance with the requirements. For example, from October 2008 through April 2010, the San Francisco regional office reported withholding a total of \$302.7 million in federal funding for Hawaii because the state's contracts and rates did not meet the actuarial soundness requirements. In contrast, officials we interviewed from the Atlanta regional office said that the office would release federal funds to a state even if the state's rates had not yet been approved by CMS.
- **Criteria for full and partial reviews.** CMS regional officials had different interpretations of when full versus partial reviews of rate setting were necessary. For example, officials from the New York regional office told us that they completed a full review for each rate-setting submission received, regardless of the changes made to rates or rate setting. In contrast, a Kansas City regional office official told us that she completed a partial review in cases where the state adjusted the rates but had not changed the data used as the basis for rates.
- **Sufficient evidence for compliance.** Regional office officials varied in how they determined sufficient evidence for state compliance with certain requirements. For example, for the requirement that rates are for Medicaid-eligible individuals covered under the contract, officials from the San Francisco regional office told us that, while they had verified information provided by states on the populations covered under the rates, they mainly looked for an assurance from the state that rates were for eligible populations. In contrast, a Kansas City regional office official explained that an assurance from the state alone would not be sufficient. Rather, the official would require evidence of the eligible populations included in, and excluded from, the rate-setting methodology.
- **Other variations.** Variations in other regional office practices may also have contributed to the inconsistency in CMS oversight. For example, management oversight of rate-setting reviews in regional offices varied. A Kansas City regional official who reviews states' rate setting told us that, prior to approving states' rates, she submitted memoranda outlining the impact of states' proposed rate changes and the rationale for

recommending approval of the package to her regional office managers. In contrast, officials from the New York regional office told us that most officials responsible for reviewing and approving states' rate setting worked independently and managers did not review a completed checklist. Other variations in practices that may have had an effect on CMS oversight included differences in training and standard procedures for conducting and documenting reviews.

As a result of our review, CMS took a number of steps that may address some of the variation in regional office practices. For example:

- officials from two regional offices told us that their offices were implementing new standard procedures to address inconsistencies in reviews identified through the course of GAO's work; and
- in December 2009, CMS began requiring that regional offices use the checklist in reviewing all states' rate-setting submissions and assure central office of its use before approving a state's rates.

However, as we reported above, variations existed even when the checklist was used, such as in the extent to which CMS officials using the checklist cited evidence of compliance for each of the actuarial soundness requirements.

CMS's Limited Efforts Do Not Ensure the Quality of the Data Used to Set Rates

CMS's efforts to ensure the quality of the data used to set rates were generally limited to requiring assurances from states and health plans, which did not provide the agency with sufficient information to ensure data quality. CMS regulations require states to describe the data used as the basis for rates and provide assurances from their actuaries that the data were appropriate for rate setting.²⁷ The regulations also specify that states using data submitted by the health plans as the basis for rates must require executives from the health plans to attest that the data are accurate, complete, and truthful. The regulations do not include requirements for the type, amount, or age of data or standards for the reasonableness or adequacy of rates. Additionally, CMS does not require states to submit documentation about the quality of the data used to set rates. In our interviews with regional office officials, we found that, when

²⁷The regulations require assurances that rates are based only upon services covered under the state Medicaid plan or costs related to providing these services, such as health plan administration, and provided under the contract to Medicaid-eligible individuals.

reviewing states' descriptions of the data used for rate setting, CMS officials focused primarily on ensuring the appropriateness of the data used by states to set rates rather than their reliability. This included reviewing the specific services and populations included in the base-year data or checking for assurances of appropriateness from the states' actuaries.²⁸ CMS officials noted that if they had concerns with the quality of a state's data they would ask the state questions. None of the officials, however, reported taking any action beyond asking questions.

With limited information on the quality of data used to set rates, CMS cannot ensure that states' managed care rates are appropriate and risks mispending billions of federal and state dollars. Actuarial certification does not ensure that the data used to set rates are reliable. In particular, 9 of the 28 files we reviewed included a disclaimer in the actuary's certification that if the data used were incomplete or inaccurate then the rates would need to be revised. Additionally, in more than half of the 28 files we reviewed, the actuaries noted that they did not audit or independently verify the data and relied on the state or health plans to ensure that the data were accurate and complete.²⁹ Officials from three of the five health plans we spoke with raised concerns about the completeness of the encounter data used by states to set rates. Additionally, state auditors in Washington have raised concerns about the lack of monitoring of the accuracy of data used for rate setting. The auditors found that the state did not verify the accuracy of the data used as the basis for Medicaid managed care rates in fiscal years 2003 through 2007. The state auditor's report from fiscal year 2007 concluded that the risk of paying health plans inflated rates increased when the accuracy of data used to establish rates could not be reasonably assumed to be correct.³⁰

²⁸ Officials from five of the regional offices we spoke with indicated that they looked at states' rate-setting submissions for information on the age or number of years of data, although some of the officials indicated that there was no standard for the age or amount of data.

²⁹ According to actuarial standards of practice, actuaries are not required to audit the data used to set rates and may rely on those providing the data, in these cases the state and health plans, to ensure the data's accuracy and completeness.

³⁰ State of Washington, Office of Financial Management, *Single Audit Report for the Fiscal Year Ended June 30, 2007* (March 2008).

States have information on the quality of data used for rate setting—information that CMS could obtain. State officials we spoke with reported having information on, and efforts intended to ensure, the quality of the data used to set rates. For example, New Jersey officials told us that the state tested the reliability and accuracy of the health plan financial data used to set rates against encounter data and required health plans to have an independent auditor review selected portions of the financial data. Additionally, Arizona officials indicated that the state periodically completes validation studies of the state’s encounter data in which they traced a sample of the encounters back to individuals’ medical records.³¹ State officials indicated that CMS used to require the state to submit results of these studies as a condition of operating its managed care program.³² However, given the state’s extensive experience with managed care, CMS no longer requires the state to submit these studies for all participating health plans.³³ (See app. III for a summary of selected states’ efforts intended to ensure data quality.) Without requiring and reviewing information on states’ data quality efforts, CMS cannot ensure that these data are of sufficient quality to be used for setting rates.

In addition to information from states, CMS conducts audits that could have provided CMS officials relevant information about the quality of the data used to set rates. For example, when describing the state’s efforts to ensure the quality of data used to set rates, officials from South Carolina noted that CMS periodically reviews the state’s FFS data through the

³¹The validation study of health plan data for one of the state’s managed care programs for contract year 2007—the contract year at issue in the CMS file we reviewed for this state program—found error rates that were above the limits set by the state. The state was planning a number of steps to reduce those error rates.

³²This state operates its Medicaid managed care program under an 1115 waiver. Under section 1115 of the Social Security Act, the Secretary of Health and Human Services may waive certain federal requirements for demonstrations the Secretary deems likely to promote Medicaid objectives. The terms of such a waiver can include such reporting requirements as were discussed above.

³³According to CMS officials, under the terms of Arizona’s current waiver, the state is not required to provide CMS the results of validation studies for health plans already participating in the state’s Medicaid managed care programs. However, the state must submit validation studies to CMS when a new health plan begins participating in the state’s programs. CMS officials confirmed that the results of any validation studies are not considered when reviewing the state’s rate-setting methodology.

Payment Error Rate Measurement (PERM) program.³⁴ Error rates calculated using FFS and encounter data through the PERM program could provide CMS with insights regarding the quality of the data that some states use to set rates. In CMS's rate-setting review file for South Carolina, however, there was no discussion of PERM results by either the state or CMS. CMS central office officials confirmed that regional office staff do not consider the results of data studies, such as state validation or PERM program reports, when reviewing states' rate-setting submissions.

CMS also could have conducted or required periodic audits of the data used to set rates. In Medicare Advantage, which is Medicare's managed care program, CMS is required to conduct annual audits of the financial records of at least one-third of the organizations participating in the program.³⁵ For Medicaid, however, CMS had not conducted any recent audits or studies of states' rate setting, including the quality of data used. Specifically, officials in all six of the regional offices we spoke with told us that they had not performed any audits or special studies of states' rate setting. Officials from CMS's central office were also not aware of any recent audits or studies done by the four other regional offices. In addition, officials from CMS's central office told us that they could only recall one instance, in the nearly 8 years since the regulations were issued, where OACT arranged for an independent assessment of a state's rate setting; that assessment was done more than 2 years ago.

Conclusions

The statutory and regulatory requirements for actuarially sound rates are key safeguards in efforts to ensure that federal spending for Medicaid managed care programs is appropriate, which could help avoid significant overpayments and reduce incentives to underserve or deny enrollees' access to needed care. CMS, however, has been inconsistent in ensuring that states are complying with the actuarial soundness requirements and

³⁴The PERM program attempts to measure improper payments in the Medicaid program using contractors to perform statistical calculations, medical records collection, and medical/data processing review of selected state Medicaid FFS and managed care claims. The program annually reviews 500 FFS and 250 managed care payments from 17 states. Its fiscal year 2007 review found a national error rate of 8.9 percent for FFS data and 3.1 percent for managed care data.

³⁵See Social Security Act § 1857(d)(1). The contract year 2006 audits for the Medicare Advantage program, which serves as an alternative to Medicare's traditional FFS program, included reviewing the accuracy of the data used to develop contract bids and ensuring that plans' rates were developed consistent with the ASOPs specified by CMS. These audits are arranged by OACT.

does not have sufficient efforts in place to ensure that states are using reliable data to set rates. During the course of our work, CMS took steps to address some of the variation in regional office practices that contributed to inconsistencies in overseeing state compliance, such as requiring regional office officials to use the checklist in reviewing all states' rate-setting submissions. While these are positive steps, they do not address all of the variations in regional office practices that contributed to inconsistencies in CMS's oversight of rate setting. For example, these steps do not address variations in tracking state compliance, which may have led to CMS's failure to review Tennessee's rates for compliance with the actuarial soundness requirements. Additionally, the steps taken do not address the variation in what evidence CMS officials considered sufficient for compliance, how officials used the checklist to document their reviews, and what conditions were necessary for federal funds to be released. CMS also does not have sufficient efforts in place to ensure the quality of the data states used to set rates, relying on assurances from states without considering any other available information on the quality of the data used. By relying on assurances alone, the agency risks reimbursing states for rates that may be inflated or inadequate.

As a result of the weaknesses in CMS's oversight, billions of dollars in federal funds were paid to one state for rates that were not certified by an actuary, and billions more may be at risk of being paid to other states for rates that are not in compliance with the actuarial soundness requirements or are based on inappropriate and unreliable data. Given the complexity of overseeing states' unique and varied Medicaid programs, it is appropriate that CMS would allow for flexibility in states' rate setting and would expect states to have the primary responsibility for ensuring the quality of the data used to set rates. However, CMS needs to ensure that all states' rate setting complies with all of the actuarial soundness requirements and needs to have safeguards in place to ensure that states' data quality efforts are sufficient. Improvements to CMS's oversight of states' rate setting will become increasingly important as coverage under Medicaid expands to new populations for which states may not have experience serving, and may have no data on which to base rates.

Recommendations for Executive Action

To improve oversight of states' Medicaid managed care rate setting, we recommend that the Administrator of CMS take three actions.

To improve consistency in the oversight of states' compliance with the Medicaid managed care actuarial soundness requirements, we recommend that the Administrator of CMS:

-
- implement a mechanism for tracking state compliance, including tracking the effective dates of approved rates; and
 - clarify guidance for CMS officials on conducting rate-setting reviews. Areas for clarification could include identifying what evidence is sufficient to demonstrate state compliance with the requirements, the conditions necessary for federal funds to be released, and how officials should document their reviews.

To better ensure the quality of the data states use in setting Medicaid managed care rates, we recommend that the Administrator of CMS make use of information on data quality in overseeing states' rate setting. CMS could, among other things, require states to provide CMS with a description of the actions taken to ensure the quality of the data used in setting rates and the results of those actions; consider relevant audits and studies of data quality done by others when reviewing rate setting; and conduct or require periodic audits or studies of the data states use to set rates.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for its review and comment. HHS concurred with all three of our recommendations, and commented that it appreciated our efforts to highlight improvements that CMS can make in its oversight of states' compliance with Medicaid managed care actuarial soundness requirements, as well as its focus on the quality of data used to set managed care rates. Moreover, HHS noted that CMS has identified many of the same issues. (See app. IV for a copy of HHS's comments.)

HHS agreed with our two recommendations related to improving the consistency of CMS's oversight, namely that CMS implement a mechanism for tracking state compliance with the actuarial soundness requirements and clarify guidance for CMS officials on conducting rate-setting reviews. HHS noted that CMS has established a managed care oversight team to develop and implement a number of improvements in its managed care oversight, some of which will address our recommendations. These improvements included CMS's plans to develop standard operating protocols for the review and approval of Medicaid managed care rates and provide comprehensive training to CMS staff on all aspects of the new process and requirements. As CMS implements efforts aimed at improving its oversight, we reiterate the need to implement a mechanism for tracking state compliance with actuarial soundness requirements, including the effective dates of rates.

HHS also agreed with our recommendation that CMS make use of information on data quality in overseeing states' rate setting. In commenting on our finding related to CMS's limited efforts to ensure data quality, HHS noted that a number of requirements within PPACA will give CMS additional authority and responsibility for acquiring and utilizing Medicaid program data.³⁶ In response to our recommendation, HHS noted that, as part of a broader effort to redesign how it collects Medicaid data, CMS will be setting standards for the type and frequency of managed care data submissions by states. HHS commented that with more complete data at its disposal, CMS will be able to better assess the underlying quality of data submissions and, thus, better execute its oversight and monitoring responsibilities. CMS should use these assessments and other available information when overseeing states' rate setting. Finally, HHS provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Administrator of CMS and other interested parties. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or 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 who made major contributions to this report are listed in appendix V.



Carolyn L. Yocom
Acting Director, Health Care

³⁶In its comments, HHS refers to PPACA as the Affordable Care Act.

Appendix I: Methodology for Selecting CMS Regional Offices and Analyzing CMS's Medicaid Managed Care Rate-Setting Files

To assess the Centers for Medicare & Medicaid Services's (CMS) oversight of states' compliance with the Medicaid managed care actuarial soundness requirements, we conducted a structured review of CMS files from 6 of the 10 CMS regional offices. We selected CMS regional offices that:

- represented at least 5 of the 10 CMS regional offices,
- collectively had oversight responsibility for at least 65 percent of the 34 states with comprehensive Medicaid managed care programs, and
- were geographically diverse and oversaw states with Medicaid managed care programs ranging in size.

The six regional offices that we selected for our review had oversight responsibility for 26 of the 34 states (or 76 percent) with comprehensive Medicaid managed care programs.¹ According to information from CMS, these 26 states accounted for about 85 percent of Medicaid managed care enrollment nationally in 2008 and state program size ranged from 8 percent of Medicaid enrollees in Illinois to 100 percent in Tennessee. (See table 3.)

Table 3: CMS Regional Offices Reviewed

CMS regional office	Number of states in region with comprehensive Medicaid managed care programs	Range in size of state programs (percentage of Medicaid enrollees in Medicaid managed care)	Percentage of national Medicaid managed care enrollment
Atlanta	5	20% to 100%	14.8
Chicago	6	8% to 71%	18.7
Kansas City	3	16% to 48%	2.5
New York	2	64% to 72%	16.0
Philadelphia	6	45% to 70%	10.7
San Francisco	4	47% to 91%	22.2
Total	26		84.9

Source: GAO analysis of 2008 Medicaid managed care data published by CMS.

¹In comprehensive managed care programs, health plans provide a full range of health care services. In addition to managed care programs that provide comprehensive services, some states have also implemented managed care for targeted categories of services.

We conducted a structured review of a selection of files from the six CMS regional offices. Specifically, we reviewed the files for CMS's rate-setting reviews of the most recently approved contract for each state's comprehensive managed care program, or, for states with multiyear contracts, the file for the most recent full review of rate setting completed as of October 31, 2009.² Several states in the selected regions had multiple comprehensive managed care programs that had separate contracts and rate-setting processes each subject to CMS review and approval. For states that had two programs, we selected the file for the program CMS officials indicated was the largest, as defined by the number of enrollees and estimated expenditures.³ For the states that had more than two programs, we selected the files for the two largest programs. For 2 of the 26 states overseen by the six regional offices (Nebraska and Tennessee), CMS had not done a review that met our criteria, so we did not review a file for those states.⁴ In total, we reviewed 28 files, which covered 24 states, 4 of which had two or more programs for which CMS did separate reviews. (See table 4.)

²Full reviews are those that cover all of the sections of CMS's checklist. Officials may also conduct partial reviews, which focus on a narrower set of the requirements covered in the checklist. We did not review any files that documented only a partial review.

³There was one exception to this rule. Florida had two programs that underwent separate CMS reviews. Because CMS indicated that one program was larger in terms of expenditures and the other was larger in terms of the number of enrollees, we included the files for both programs in our review.

⁴While we did not review CMS rate-setting review files for Nebraska and Tennessee, we asked CMS officials about their oversight of those states' rate setting and reviewed relevant documents the states submitted to CMS.

**Appendix I: Methodology for Selecting CMS
Regional Offices and Analyzing CMS's
Medicaid Managed Care Rate-Setting Files**

Table 4: Description of the 28 CMS Medicaid Managed Care Rate-Setting Files Reviewed

CMS regional office	State	Medicaid managed care program included in review	Time period of rates covered in review	Change in rates from prior year	Actuarial firm that certified the rates
Atlanta	Florida	Non-Reform	September 2008-August 2009	Decrease	Milliman
	Florida	Medicaid Reform	September 2008-August 2009	Decrease	Mercer
	Georgia	Georgia Families Program	July 2009-June 2010 ^a		Aon
	Kentucky	Kentucky Partnership Program	July 2009-June 2010 ^a		PriceWaterhouse Coopers
	South Carolina	Medicaid managed care	April 2008-March 2009	^a	Deloitte Consulting
Chicago	Illinois	Risk-Based Managed Care	August 2008-July 2009	Decrease	Milliman
	Indiana	Hoosier Healthwise	January 2009-December 2009	Increase	Milliman
	Michigan	Comprehensive Health Care Plan	October 2008-September 2009	Increase	Milliman
	Minnesota	Prepaid Medical Assistance Program	January 2009-December 2009	Increase	Milliman
	Minnesota	MinnesotaCare	January 2009-December 2009	Increase	Milliman
	Ohio	Covered Families and Children	January 2008-December 2008	Increase	Milliman
	Wisconsin	BadgerCare Plus	January 2009-December 2009	Increase	PriceWaterhouse Coopers
Kansas City	Kansas	HealthWave 19	July 2008-June 2009	Decrease	Mercer
	Missouri	HealthNet Managed Care Program	October 2009-June 2010	Decrease	Mercer
New York	New Jersey	Medicaid managed care	July 2009-June 2010	Increase	Mercer
	New York	Medicaid Managed Care and Family Health Plus	April 2008-March 2009	^a	Mercer
Philadelphia	Delaware	Diamond State Health Plan	July 2007-June 2009	Increase	Solucia
	District of Columbia	District of Columbia Healthy Families Program	May 2008-April 2009	Decrease	Mercer
	Maryland	HealthChoice	January 2009-December 2009	Increase	Mercer
	Pennsylvania	HealthChoices Physical Health	July 2008-June 2009 ^a		Mercer

**Appendix I: Methodology for Selecting CMS
Regional Offices and Analyzing CMS's
Medicaid Managed Care Rate-Setting Files**

CMS regional office	State	Medicaid managed care program included in review	Time period of rates covered in review	Change in rates from prior year	Actuarial firm that certified the rates
	Virginia	Medallion II	July 2009-June 2010	Increase	PriceWaterhouse Coopers
	West Virginia	Mountain Health Trust	July 2009-June 2010	Increase	Lewin
San Francisco	Arizona	Arizona Health Care Cost Containment System Acute Care Program	October 2008-September 2009	Increase	State self-certified
	Arizona	Arizona Long-Term Care System	October 2006-September 2007	Increase	State self-certified
	California	Two Plan Model	October 2008-September 2009	^a	Mercer
	California	County Organized Health System	July 2009-June 2010	^a	State self-certified
	Hawaii	QUEST	July 2009-October 2009	Decrease	Milliman
	Nevada	Medicaid managed care	January 2009-December 2009	Increase	Milliman

Source: GAO analysis of CMS documentation.

^aFor this program, the CMS file did not provide a clear indication of how the rates changed from the prior year. This may have been for a number of reasons. For example, the documentation may have indicated increases in rates for some populations and decreases for others but not provide a description of the aggregate effect on rates; or the documentation may have indicated a change in expenditures but not describe whether this resulted from a change in enrollment or a change in rates.

As part of our file review, we assessed the degree to which CMS documented its review. Specifically, we determined whether the CMS official completed CMS's checklist—a tool CMS developed for regional office staff to use when reviewing states' rate-setting submissions for compliance with the actuarial soundness requirements.⁵ For those files where the CMS official did not complete the checklist and provided no other documentation of the review, we did no further assessment of CMS's review. For the files where the CMS official completed the checklist, we assessed the extent to which CMS ensured that the state complied with the actuarial soundness requirements. To do this, we identified several requirements of the regulations, including that rates were certified by a qualified actuary, that rates were based on covered services for eligible

⁵The checklist includes citations to, and a description of, each regulatory requirement; guidance on what constitutes state compliance with the requirement; and spaces for the CMS official to check whether each requirement was met and cite evidence from the state's submission for compliance with the requirement.

individuals, and that the state documented any adjustments to the base year data. For these requirements, we assessed whether (1) CMS documented that the state met the requirement, (2) CMS cited evidence for the assessment that the state was in compliance, and (3) the cited evidence was consistent with the guidance in CMS's checklist. Additionally, as part of our review, we summarized descriptive elements of states' rate setting and rates. For example, we documented the types of data used as the basis for rates and how the state's rates changed from the prior year. To ensure the accuracy of the information collected as part of our structured review of the files, we conducted independent verifications of each review.

Appendix II: Methodology for Selecting States to Contact

To describe state views of the Centers for Medicare & Medicaid Services’s (CMS) oversight of state compliance with the Medicaid managed care actuarial soundness requirements and state efforts to ensure the quality of the data used to set rates, we selected 11 of the 34 states with comprehensive Medicaid managed care programs and interviewed officials from those states’ programs. We selected states that:

- were geographically diverse;
- varied in the size of their Medicaid managed care programs, as defined by the numbers of managed care enrollees, the proportion of states’ Medicaid population that were in managed care, and the number of MCOs participating in the program; and
- overlapped with the oversight responsibilities of the six selected CMS regional offices.

Table 5 provides information about the selected states.

Table 5: Information about the Medicaid Managed Care Programs of Selected States, as of 2008

State	Medicaid managed care enrollment	Percentage of national Medicaid managed care enrollment	Percentage of state’s Medicaid population enrolled in managed care	Number of health plans participating in Medicaid managed care	CMS regional office with oversight responsibility
Arizona	949,404	5	91	More than 15	San Francisco
California	3,395,468	16	51	More than 15	San Francisco
Florida	813,427	4	36	More than 15	Atlanta
Indiana	582,714	3	66	Fewer than 6	Chicago
Maryland	491,274	2	69	From 6 to 15	Philadelphia
Nebraska	32,716	Less than 1	16	Fewer than 6	Kansas City
New Jersey	659,586	3	72	Fewer than 6	New York
New York	2,663,935	13	64	More than 15	New York
Pennsylvania	968,713	5	53	From 6 to 15	Philadelphia
South Carolina	184,526	1	27	From 6 to 15	Atlanta
Tennessee	1,207,136	6	100	From 6 to 15	Atlanta

Source: GAO analysis of CMS’s 2008 Medicaid managed care enrollment report and CMS’s organizational chart.

Appendix III: Selected States' Reported Efforts Intended to Ensure the Quality of the Data Used to Set Rates

The 11 states we interviewed used a combination of approaches intended to ensure the quality of the data used in Medicaid managed care rate setting. These included front-end efforts intended to prevent errors in data reported by providers and health plans, reconciliation methods to help ensure the reliability and appropriateness of reported data, and in-depth reviews that identified and addressed issues of ongoing concern. See table 6 for a summary of the selected states' efforts intended to ensure data quality.

Table 6: Eleven States' Reported Efforts Intended to Ensure the Quality of Data Used to Set Medicaid Managed Care Rates

Type of effort	Efforts	Number of states reporting	Examples
Front-end efforts	Data edits	7	South Carolina's information system checked fee-for-service data against a set of edits that rejected inappropriate claims and checked the data for internal consistency.
	Data reporting requirements for health plans	8	Maryland had standard reporting guidelines for financial data to ensure the reliability of the data. New York required financial data to be certified by health plans' chief executive officer and chief financial officer.
Efforts to reconcile reported data	Reconciliation of data with other data sources	9	California reconciled financial data used to set rates with enrollment data to ensure that the data were only for individuals eligible under the managed care contract. Pennsylvania compared health plan-provided enrollee data to state data to ensure that the health plans' cost reports reflected all eligibility groups covered under the managed care contract.
	Checks for internal consistency and completeness	11	Tennessee information technology staff reviewed submitted encounter data reports quarterly to identify duplicate or high-cost claims, which are returned to health plans for explanations and adjustments as necessary.
In-depth reviews	Audits or reviews	9	Maryland contracted with an outside organization to annually audit financial data from each health plan with which it contracts. Arizona completed annual validation studies of encounter data, which included tracing encounter data submitted by health plans to information in medical records. Florida convened a workgroup to review its rate-setting process including the appropriateness of the data used as the basis for rates; the review found that the FFS data used no longer reflected the experience of the state's managed care population.

Source: GAO analysis of information reported by state officials.

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

JUL 23 2010

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

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled: "MEDICAID MANAGED CARE: CMS's Oversight of States' Rate Setting Needs Improvement" (GAO-10-810).

The Department appreciates the opportunity to review this correspondence before its publication.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrea Palm", written over a horizontal line.

Andrea Palm
Deputy Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TO THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID MANAGED CARE: CMS' OVERSIGHT OF STATES' RATE SETTING NEEDS IMPROVEMENT" (GAO-10-810)

The Department appreciates the opportunity to review and comment on this GAO draft report. We appreciate GAO's efforts to highlight improvements that the Centers for Medicare & Medicaid Services (CMS) can make in its oversight of States' compliance with Medicaid managed care actuarial soundness requirements and focus on data quality used to set managed care rates; the agency has identified many of the same issues.

CMS is implementing a broad set of initiatives to strengthen its oversight and compliance of managed care services and to ensure access to services and quality of care for all Medicaid beneficiaries. Managed care has been a valuable development for Medicaid beneficiaries over the past decade, but the growth in managed care gives rise to the need for increased Federal oversight to assure sound payment rates and access to care. This is necessary not just to ensure that current beneficiaries receive high-quality care, but also to prepare Medicaid's delivery system for the significant increase in eligible beneficiaries under the Patient Protection and Affordable Care Act (Affordable Care Act), many of whom will likely enroll in managed care.

As part of these oversight efforts, CMS is also implementing section 403 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which applied substantially all of the statutory Medicaid managed care requirements to the Children's Health Insurance Program (CHIP) "in the same manner" as they apply to Medicaid.

These recent legislative changes make it even more critical for CMS, working with States, to implement rigorous improvements in managed care monitoring and oversight. The improvements will focus on States' performance in meeting regulatory requirements as well as their assurance that their managed care systems deliver accessible, available and appropriate services to Medicaid beneficiaries.

GAO's Findings and CMS Actions to Date

During its review, GAO found that CMS' oversight of States' compliance with actuarial soundness requirements has been inconsistent, due, in part, to variation in regional office (RO) practices. By the time GAO initiated this review, CMS had identified these inconsistencies as a concern and had begun developing a plan for corrective action. This plan would strengthen both oversight of actuarial soundness compliance and our approach to managed care program reviews in order to ensure adequate access to and quality of care provided to beneficiaries. In December 2009, the Administrator of the Consortium for Medicaid and Children's Health Operations issued a directive to the Medicaid Associate Regional Administrators that the existing contract review and capitation rate review checklists must be used and documented before either the contract or capitation rates are approved.

GAO also found that CMS's limited efforts do not ensure the quality of the data used to set rates. A number of statutory requirements in the Affordable Care Act will give CMS additional authority, as well as, responsibility for acquiring and utilizing Medicaid program data. Current Medicaid statute and regulations require managed care organizations (MCOs) to keep patient-specific encounter data and make that data available to the State and CMS. However, section

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TO THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID MANAGED CARE: CMS' OVERSIGHT OF STATES' RATE SETTING NEEDS IMPROVEMENT" (GAO-10-810)

6402 of the Affordable Care Act, effective March 23, 2010, requires States to report MCO encounter data to the Secretary or face reduced Federal financial participation. This action should improve CMS' access to encounter data and enable analysis of the data used for rate setting by using encounter data as a comparison point.

GAO Recommendations

To improve consistency in the oversight of States' compliance with these requirements, CMS should--

- (1) Implement a mechanism for tracking State compliance, including tracking the effective dates of approved rates;
- (2) Clarify guidance for CMS officials on conducting rate-setting reviews; and
- (3) Make use of information on data quality in overseeing States' rate setting.

CMS Response

As noted above, CMS has identified many of the same issues regarding the need for more robust oversight of managed care rates and the need to address inconsistencies in our approach to reviewing managed care rate setting. The following is a description of the initiatives that we have underway to improve our oversight of Medicaid managed care plans and responses to the recommendations raised in this report.

Recommendations 1 and 2

We concur fully with GAO's first two recommendations. CMS has identified key elements needed to move toward rigorous and consistent oversight and monitoring of Medicaid and CHIP managed care programs operating under any statutory authority and using any delivery system model. These key elements address the specific recommendations made by GAO, but also include other components of an improved managed care oversight program. CMS has established a managed care oversight team to develop and implement a number of improvements, including--

- *Standard Operating Protocols (SOP) for the review and approval of Medicaid and CHIP managed care contracts.* These SOPs will address workflow and process and set standard timelines for contract review;
- *Medicaid contract review checklist - updates and directions for use.* The new checklist will include instructions and technical guidance for the review of implementation evidence, compliance criteria, and sanctions for noncompliance, including the withholding of funds;
- *CHIP contract review checklist.* This activity is dependent upon publication of regulatory requirements for CHIP managed care oversight. In the interim, a tool

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TO THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID MANAGED CARE: CMS' OVERSIGHT OF STATES' RATE SETTING NEEDS IMPROVEMENT" (GAO-10-810)

- addressing the statutory requirements of Section 403 of CHIPRA will be developed and implemented;
- *Online contract review tool.* The tool will provide contract-related data aggregation capabilities and ensure consistency and workflow. It will permit CMS to track State compliance with specific criteria, as well as conduct service- or population-specific audits of State programs. It will also enable review triggers to be set and monitored on a regular basis;
 - *Standard Operating Protocols for the review and approval of managed care rates.* CMS will clearly define the circumstances under which a full or partial rate review will be performed and will incorporate standards for the type, amount, and age of data used to set rates to assure appropriateness of data quality. A process will also be designed to document health plan executives' certification regarding the accuracy and completeness of data. CMS will enlist staff from the Office of the Actuary (OACT) in this effort and build OACT consultation into the review process, to the extent feasible;
 - *Guidelines for consistent interpretation and enforcement of regulatory requirements.* To ensure national consistency to the extent possible, definitions and expectations related to requirements for access and availability of services will be developed and applied;
 - *Managed care program monitoring/review guides – updates and directions for use.* The existing guide will be revamped to be of use for any type of managed care program, and will include expanded data review and program integrity modules;
 - *Formal dissemination of sub-regulatory guidance to States.* State Medicaid Director and/or State Health Official letters will accompany CMS guidance on compliance expectations and requirements, and training provided as needed;
 - *Training for CMS staff.* As new processes and requirements are developed and implemented, staff responsible for oversight and monitoring of Medicaid and CHIP programs will be trained on them. Additionally, once all improvements are in place, staff will receive intensive and comprehensive training covering all aspects of the new processes and requirements; and
 - *Shared and accessible resource library* of policies and procedures for CMS staff in Baltimore and ROs.

RO staff has already made substantial progress in reviewing and making preliminary revisions to the two compliance checklists. The managed care oversight team, composed of CMS staff and managers from Baltimore and the ROs, is working to finalize these and distribute them as formal CMS guidance by November 2010. We also expect to have the contract review SOP issued by that date. These documents will populate the CMS managed care oversight resource library.

At the same time, the team will work throughout the remaining half of this year and into 2011 to develop the additional elements of our managed care oversight improvement plan, including guidelines for interpreting and enforcing our regulatory requirements, providing additional guidance for States, and training for CMS staff. The oversight team will also work on an ongoing basis to ensure that new statutory and regulatory provisions affecting Medicaid and CHIP managed care are reflected in CMS guidance documents, protocols and tools. The team will report to CMS leadership on a regular basis on the implementation of these new approaches

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TO THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID MANAGED CARE: CMS' OVERSIGHT OF STATES' RATE SETTING NEEDS IMPROVEMENT" (GAO-10-810)

and make recommendations about what additional oversight efforts and approaches are needed. Finally, CMS will explore, with the American Academy of Actuaries, possible development and/or refinement of Standards of Practice for Medicaid and CHIP managed care rate setting.

Recommendation 3

We concur and acknowledge improvements we need to make regarding the third recommendation. The CMS has already recognized that data validation and analysis is a critical component in the efficient operation of the Medicaid program. CHIPRA, the American Recovery and Reinvestment Act and the Affordable Care Act contain many new provisions to enhance the scope and quality of the Medicaid/CHIP programs; these provisions also implement a number of new programs that require more and better information to operate efficiently.

Currently, CMS is undertaking a fundamental redesign of Medicaid data collection and the development of robust analytical functionality that will offer strategic programmatic insights of use to States, Federal partners, and other stakeholders. In collaboration with States, CMS' redesign will use a comprehensive performance and quality management approach to implement nationally consistent data collection, aggregation, and analysis methods that can be used for program integrity, fiscal accountability, program effectiveness and effective program management.

Managed care data collection is a critical component of these efforts, in light of the increasing prominence of managed care delivery systems. CMS will be setting standards for the type and frequency of managed care data submissions by States in order to expand the type and consistency of data on managed care programs. With more complete data at its disposal, CMS will be able to implement more rigorous analysis to assess the underlying quality of data submissions. These analyses can then be used to help CMS better execute its oversight and monitoring responsibilities, including ensuring the actuarial soundness of managed care rates. The data will also be of use to States as they administer their managed care programs.

CMS appreciates GAO's efforts to highlight areas of improvement for managed care rate-setting oversight. CMS intends to take these findings and recommendations and incorporate them into the larger compliance monitoring and oversight plan we are developing. CMS looks forward to working with GAO as we proceed to address these issues. CMS is committed to ensuring that States' managed care delivery systems provide the highest quality care to Medicaid recipients, while ensuring access to all program services in the most efficient and effective manner possible.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

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

Acknowledgments

In addition to the contact named above, Michelle Rosenberg, Assistant Director; Joseph Applebaum, Chief Actuary; Susan Barnidge; William A. Crafton; Drew Long; Kevin Milne; and Dawn D. Nelson made key contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday afternoon, GAO posts on its Web site newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's Web site, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@gao.gov, (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

