Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MULTIPLE STATES MADE MEDICAID CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS AFTER ENROLLEES' DEATHS

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Inspector General

November 2023
A-04-21-09005

Office of Inspector General

https://oig.hhs.gov

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Report in Brief
Date: November 2023
Report No. A-04-21-09005

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths

Why OIG Did This Audit

HHS-OIG has identified effectively administering the Medicaid program to improve oversight and address high improper payments as a top management challenge facing the HHS.

Fourteen previous OIG audits found that State Medicaid agencies had improperly made capitation payments to managed care organizations (MCOs) on behalf of deceased enrollees.

Our objective was to summarize the results of our previous audits of Medicaid capitation payments that States made to MCOs on behalf of deceased enrollees. In addition, we sought to identify steps that CMS could take to reduce these unallowable payments.

How OIG Did This Audit

Our prior 14 audits covered 450,562 Medicaid capitation payments totaling $318,167,200 that States made to MCOs on behalf of deceased enrollees during audit periods ranging from July 1, 2009, through December 31, 2019. We used statistical sampling and data analytics to select 50,292 Medicaid capitation payments totaling $16,270,039 for review. To identify steps that CMS could take to improve its Medicaid oversight, we interviewed CMS officials and assessed its internal controls related to its resolution of the audit findings as well as its internal controls specific to ensuring that States are sufficiently preventing Medicaid capitation payments from being made to MCOs on behalf of deceased enrollees.

What OIG Found

In our previous audits of 14 States, we identified more than $249 million ($172 million Federal share) in unallowable Medicaid capitation payments that the States made to MCOs on behalf of deceased enrollees. These unallowable payments occurred for various reasons. CMS concurred with all of our recommendations made to the States in our prior audit reports and has ensured that actions have been taken on most of our recommendations.

In this audit, we identified additional actions CMS could take to help States that continue to make improper capitation payments to MCOs on behalf of deceased enrollees. Specifically, CMS could develop a process to routinely match Transformed Medicaid Statistical Information System (T-MSIS) enrollment data against the Social Security Administration's (SSA's) Death Master File (DMF) data to determine States that are at a high risk of making improper payments to MCOs on behalf of deceased enrollees. CMS could then provide the results of the data match to high-risk States for further verification of whether improper payments were made, and those States could use the results of the data match review to develop corrective actions and improve controls to detect and prevent such payments.

What OIG Recommends and CMS Comments

We recommend that CMS take the following steps: (1) collect the outstanding unallowable payments totaling the estimated $41,003,804 we previously identified, (2) ensure that States complete actions on our remaining recommendations to address the internal control weaknesses we identified, and (3) continue to explore opportunities for using T-MSIS and SSA's DMF data to improve its oversight of the Medicaid program. Specifically, CMS should develop a process to match enrollment and payment information in T-MSIS with the DMF and provide the results of that match to States to help reduce Medicaid capitation payments made to MCOs on behalf of deceased enrollees.

CMS neither concurred nor nonconcurred with our first and second recommendations, and it did not concur with our third recommendation. For our first two recommendations, CMS stated it has worked closely with States to ensure that our recommendations are implemented and requested that we update our third recommendation, as CMS contends that adding a new process could prove redundant, inefficient, and confusing to States. After reviewing CMS's comments, we maintain that our recommendations are valid.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

The Department of Health and Human Services (HHS), Office of Inspector General (OIG) has identified effectively administering the Medicaid program to improve oversight and address high improper payments as a top management challenge facing HHS.[1]

Fourteen previous OIG audits found that State Medicaid agencies had improperly made capitation payments on behalf of deceased enrollees (see Appendix B).[2]

The payments have drawn the attention of the U.S. Senate's Committee on Finance. In an October 1, 2019, letter to the Centers for Medicare & Medicaid Services (CMS), the Committee said that nearly a dozen audits by OIG and the Government Accountability Office showed that even though CMS can recoup "the Federal share of such payments in the event they are discovered . . . multiple States struggle with this issue, and greater CMS leadership is needed to resolve it."[3]

Because of the significant issues identified in our prior audits and congressional interest, we determined that it was beneficial to summarize the results of our 14 previous audits of unallowable Medicaid capitation payments that States made to managed care organizations (MCOs) on behalf of deceased enrollees and to make recommendations to CMS to address these issues.

OBJECTIVES

Our objective was to summarize the results of our previous audits of Medicaid capitation payments States made to MCOs on behalf of deceased enrollees. In addition, we sought to identify steps that CMS could take to reduce these unallowable Medicaid capitation payments.

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[1] *Top Management & Performance Challenges Facing HHS*. Available online at oig.hhs.gov/reports-and-publications/top-challenges/2016/challenge02.asp. Accessed on Oct. 3, 2023.

[2] Our 14 prior audits covered Medicaid capitation payments that States made to MCOs on behalf of deceased enrollees during audit periods ranging from July 1, 2009, through Dec. 31, 2019.

[3] U.S. Senate Committee on Finance, Medicaid Oversight Letter, Oct. 1, 2019. Available online at www.finance.senate.gov/imo/media/doc/MedicaidOversightLetter1Oct.2019SpecProjects%20-%20FINAL%20430PM.pdf. Accessed on Oct. 3, 2023.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income enrollees and individuals with disabilities through Title XIX of the Social Security Act (the Act). The Federal and State Governments jointly fund and administer the Medicaid program. CMS administers the program at the Federal level. Each State administers its Medicaid program with a CMS-approved plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid Managed Care

Medicaid managed care programs are organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between State Medicaid agencies and MCOs that accept a set per-member, per-month capitation payment for these services. A capitation payment is a payment the State makes periodically to a contractor, such as an MCO, on behalf of each enrollee under a contract and is based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the enrollee receives services during the period covered by the payment (see 42 CFR § 438.2).

States report capitation payments paid to the MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).[4] The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal medical assistance percentage, which varies depending on the State's relative per capita income as calculated by a defined formula (see 42 CFR § 433.10), with exceptions made for certain situations.

Social Security Administration's Date of Death Information

The Social Security Administration (SSA) maintains death record information by obtaining the information from a variety of sources such as relatives of deceased enrollees, funeral directors, financial institutions, and government agencies (local, State, and Federal). All death reports are then recorded on the SSA's Numerical Identification System (NUMIDENT)[5] using the

[4] Form CMS-64. Available online at medicaid.gov/Medicaid/downloads/chip-cms64-expenditure-forms.pdf. Accessed on Oct. 3, 2023.

[5] NUMIDENT contains personally identifiable information for each individual who has been issued a Social Security number. NUMIDENT is SSA's official source of death information. Death reports are recorded on the NUMIDENT using information from the Death Information Processing System. This system then automatically sends death information to SSA's payment systems.

information from its Death Information Processing System.[6] SSA then uses the NUMIDENT information to create a database called the Death Master File (DMF), which is routinely updated.[7] SSA can provide a full file of death information to States through a data exchange agreement.[8]

States' Medicaid Management Information Systems and CMS's Medicaid Statistical Information System

Medicaid's claim processing system, called the Medicaid Management Information System, was designed to meet principal objectives. The objectives of the Medicaid Management Information System include program and administrative cost controls, service to enrollees and providers, operations of claims control and computer capabilities, and management reporting for planning and control. Each State's Medicaid Management Information System stores and maintains data on Medicaid enrollees (e.g., date of birth and date of death), health care services covered, and expenditures. The system includes various subsystems that support Medicaid claims activities, as well as services provided through managed care.

Under the Balanced Budget Act of 1997, P.L. No. 105-33, States must submit Medicaid claims data to CMS through the Medicaid Statistical Information System (MSIS). The purpose of the MSIS is to collect, manage, analyze, and disseminate information on people eligible for Medicaid or already enrolled in the program, which services they use, and payments made for services covered by State Medicaid programs. In 2011, CMS began working with States to transition from the MSIS to a new system with expanded data elements. The new system, known as the Transformed MSIS (T-MSIS), was developed to improve Medicaid data and data analytic capacity.

HOW WE CONDUCTED THIS AUDIT

Our prior 14 audits covered 450,562 Medicaid capitation payments totaling $318,167,200 that 14 States made to MCOs on behalf of deceased enrollees during audit periods ranging from July 1, 2009, through December 31, 2019. We used a combination of statistical sampling and data analytics to select 50,292 Medicaid capitation payments totaling $16,270,039 for review.

This report summarizes the results of those 14 previously issued audit reports and provides information about steps CMS could take to help States reduce unallowable Medicaid capitation

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[6] SSA, *Program Operations Manual System*, GN 02602.050, May 5, 2023. Available online at https://secure.ssa.gov/poms.nsf/lnx/0202602050. Accessed on Oct. 3, 2023.

[7] SSA maintains death data—including names, Social Security numbers, dates of birth, and dates of death—in the DMF for deceased individuals. The more comprehensive file, referred to as the "full DMF," is available to certain eligible entities and includes State-reported death data. A subset of the DMF, called the "public DMF," is available to the public and does not include State-reported death data.

[8] The full file of death information is the DMF including State death records.

payments made to MCOs after enrollees' deaths. To identify steps that CMS could take to improve its Medicaid oversight, we interviewed CMS officials and assessed its internal controls related to its resolution of OIG audit findings as well as its internal controls specific to ensuring that States are sufficiently preventing Medicaid capitation payments from being made to MCOs on behalf of deceased enrollees.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology, and Appendix C contains the Federal requirements related to State Medicaid capitation payments made to MCOs on behalf of enrollees.

FINDINGS

In our previous audits of 14 States, we identified approximately $249 million ($172 million Federal share) in unallowable Medicaid capitation payments that the States made to MCOs on behalf of deceased enrollees from 2009 to 2019. These unallowable payments occurred for various reasons. CMS concurred with all of our recommendations made to the States in our prior audit reports and has ensured that actions have been taken on most of our recommendations.

In this audit, we identified additional actions CMS could take to help States that continue to make improper capitation payments to MCOs on behalf of deceased enrollees. Specifically, CMS could develop a process to routinely match T-MSIS enrollment data against SSA's DMF data to identify those States that continue to make payments to MCOs on behalf of deceased enrollees and to provide increased oversight of those States.

STATES MADE UNALLOWABLE MEDICAID CAPITATION PAYMENTS TO MCOs ON BEHALF OF DECEASED ENROLLEES

Federal Requirements

An overpayment includes any payment made to an MCO by a State to which the MCO is not entitled under Title XIX of the Act (42 CFR § 438.2). Capitation payments may only be made by the State and retained by the MCO for Medicaid-eligible enrollees (42 CFR § 438.3(c)(2)). As a result, payments made to an MCO after an enrollee's death are subject to recovery.

Medicaid Capitation Payments Made to MCOs on Behalf of Deceased Enrollees

In our prior audits of 14 States, we found that each of the States had made Medicaid capitation payments to MCOs on behalf of deceased enrollees that totaled approximately $249 million ($172 million Federal share). (See Table 1 for a list of the 14 States audited and the unallowable Medicaid capitation payments identified for each State, the Federal share of the unallowable Medicaid capitation payments, and the amount of the Federal share that had not been collected as of November 2022).

Table 1: Unallowable Medicaid Capitation Payments States Made on Behalf of Deceased Enrollees Identified in the 14 Audits We Reviewed and the Amounts That Remain Uncollected

OIG Audit Common Identification Number	State	Total Value of Unallowable Payments[9]	Federal Share of Unallowable Payments	Federal Share of Unallowable Payments That Remain Uncollected
A-04-18-06220	CA	$70,989,604	$53,425,143	$0
A-05-17-00008	OH	51,294,467	37,974,949	0
A-05-17-00048	MI	39,873,514	27,545,800	27,545,800
A-04-15-06182	FL	26,202,536	15,356,486	0
A-04-19-06223	NY	23,325,502	13,696,760	3,696,760
A-07-20-05125	KS	17,315,978	9,761,244	9,761,244
A-05-18-00026	IL	4,615,982	3,174,262	0
A-05-17-00049	MN	3,685,087	3,243,531	0
A-04-16-00112	NC	2,911,595	1,948,657	0
A-04-15-06190	TN	2,668,953	1,814,761	0
A-04-15-06183[10]	GA	2,168,278	1,626,828	0
A-06-16-05004	TX	1,768,774	1,038,875	0
A-05-19-00007	IN	1,163,487	862,097	0
A-05-17-00006	WI	589,478	347,822	0
Total		**$248,573,235**	**$171,817,215**[11]	**$41,003,804**[12]

[9] For 11 of the audits, the total value and Federal share of unallowable payments were estimated.

[10] Georgia paid back the Federal share of all identified unallowable Medicaid capitation payments that the State made on behalf of deceased enrollees before the completion and issuance of the audit report. Therefore, the audit report did not contain recommendations for Georgia to repay the unallowable Medicaid capitation payments we identified.

[11] During its audit resolution process, CMS sustained different amounts for a few States than what we recommended the States refund to the Federal Government. CMS sustained $166,538,141 associated with our 14 prior audits and has collected $125,534,337 of the sustained amounts.

[12] CMS is working with each of the three states to collect the remaining uncollected Federal share of unallowable Medicaid capitation payments made to MCOs on behalf of deceased enrollees.

Reasons States Made Unallowable Medicaid Capitation Payments to MCOs After Enrollees' Deaths

The 14 States generally made unallowable Medicaid capitation payments for the following reasons:

- 11 States did not always identify and process Medicaid enrollees' death information;
- 4 States did not use eligibility systems that interface with Federal and State data exchanges that identify dates of death (DOD), requiring agency officials to conduct manual matches between the data systems;
- 9 States did not enter the DODs in their Medicaid Management Information System even though this information was readily available, as its eligibility systems interfaced with Federal and State data exchanges that identify DODs;
- 6 States had inadequate policies and procedures to ensure that deceased enrollees were identified through their monthly reviews;
- 5 States did not regularly use all available Federal and State sources, such as Accurint,[13] obituaries, or alternative procedures, to identify, verify, or determine DODs; and
- 3 States did not collaborate with the entities that provide DOD information to identify inconsistencies between the sources of DODs.

Status of Recommendations and Overpayment Collections

CMS has collected approximately $126 million (Federal share) of these unallowable payments. In addition, CMS has confirmed that sufficient actions have been taken on 38[14] of the 46 other audit recommendations we made. Those recommendations were mostly aimed at ensuring that the States implemented or strengthened policies and procedures to address internal control weaknesses and identify any additional unallowable Medicaid capitation payments made before or after the audit periods. CMS is working with each of the 3 States associated with the 8 unimplemented recommendations to ensure that actions are taken.

[13] Accurint is a LexisNexis data depository that contains more than 65 billion records from more than 10,000 data sources. Accurint's identity repository contains death records from SSA and other sources.

[14] After the issuance of our draft report on July 20, 2023, CMS confirmed that sufficient actions had been taken on two additional audit recommendations. Therefore, this number was updated to reflect the status of audit recommendations as of Sept. 6, 2023. This update reduced the number of unimplemented recommendations from 10 to 8 and reduced the number of States associated with these recommendations from 4 to 3.

CMS COULD DO MORE TO HELP STATES THAT CONTINUE TO MAKE IMPROPER MEDICAID CAPITATION PAYMENTS TO MCOs ON BEHALF OF DECEASED ENROLLEES

While CMS has ensured that most of our recommendations made to individual States were implemented and has recovered unallowable Medicaid capitation payments made on behalf of deceased enrollees, it could do more to help States that continue to make improper capitation payments to MCOs on behalf of deceased enrollees.[15] Specifically, CMS could develop a process to routinely match T-MSIS enrollment data against SSA's DMF data (data match) to determine States that are at high risk of making improper payments to MCOs on behalf of deceased enrollees. CMS could then provide the data match results to high-risk States for further verification of whether improper payments were made, and those States could use the results of the data match review to develop corrective actions and improve controls to detect and prevent such payments. Such a process would be consistent with CMS's Comprehensive Medicaid Integrity Plan (CMIP), which sets forth CMS's strategy to safeguard the integrity of the Medicaid program by enhancing the sharing of claims data, analytics, and audit capabilities between CMS and State Medicaid agencies.[16]

The CMIP includes strategies for validating the quality and completeness of T-MSIS data with the ongoing goal of using advanced analytics and other innovative solutions to maximize the potential for program integrity purposes. To this end, a CMS contractor completed an analysis of T-MSIS data for multiple States with the goal of determining whether each State's Medicaid program had made inappropriate payments on behalf of deceased enrollees. To accomplish this goal, the CMS contractor matched Medicaid enrollment and payment data contained in T-MSIS data against SSA's DMF data to identify inappropriate payments made on behalf of deceased enrollees. As of November 2022, CMS was in the process of reviewing the results of the analyses and is considering the options for matching T-MSIS against SSA's DMF data for program integrity purposes. However, CMS has not yet established a process to routinely match T-MSIS data against SSA's DMF data to identify such payments.

[15] CMS has several Medicaid program integrity initiatives including Payment Error Rate Measurement reviews, State Program Integrity reviews, the Medicaid Eligibility Quality Control program, and the Medicaid Integrity Institute. While each of these initiatives was designed to address improper payments and improve Medicaid program integrity, they are broad in scope and were not designed or intended to specifically identify capitation payments made to MCOs on behalf of deceased enrollees.

[16] Section 1936(d) of the Act directs the Secretary of HHS to establish a plan on a recurring 5-year basis, beginning with fiscal year 2006, that ensures the integrity of the Medicaid program by taking steps to combat fraud, waste, and abuse. As part of its efforts to meet that mandate for fiscal years 2019 through 2023, CMS developed and implemented the CMIP. This 5-year plan reflects information as of Dec. 31, 2019, and was developed by CMS during calendar years 2018 and 2019 and can be found online at https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf. Accessed on Oct. 3, 2023.

RECOMMENDATIONS

We recommend that the Centers for Medicare and Medicaid Services:

- collect the outstanding unallowable payments totaling the estimated $41,003,804 we previously identified;

- ensure that States complete actions on our remaining recommendations to address the internal control weaknesses we identified; and

- continue to explore opportunities for using T-MSIS and SSA's DMF data to improve its oversight of the Medicaid program. Specifically, CMS should develop a process to match enrollment and payment information in T-MSIS with the DMF and provide the results of that match to States to help reduce Medicaid capitation payments made to MCOs on behalf of deceased enrollees.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS COMMENTS

In response to our draft report, CMS neither concurred nor nonconcurred with our first and second recommendations, and it did not concur with our third recommendation. Regarding our first two recommendations, CMS stated that it has worked closely with all 14 States to ensure that they implement OIG's recommendations as appropriate and regularly provide updates to OIG on the status of recommendations. CMS stated that most of the recommendations from the prior OIG audits have already been implemented, which demonstrates that it is committed to closing the remaining recommendations as soon as possible. CMS requested that OIG remove these recommendations given the work it has done and continues to do with States to close the remaining recommendations associated with our 14 prior audits.

CMS also requested that OIG update its third recommendation to focus on providing clearer guidance to States to help them better understand how to use the DMF to identify individuals enrolled in Medicaid who may be deceased. CMS noted that States already have access to several data sources, in addition to the DMF, that may be used to obtain information about enrollees who may be deceased. CMS said the addition of T-MSIS monitoring could prove redundant, inefficient, and confusing to States. CMS added that the time lag associated with T-MSIS file submissions from States presents potential challenges for the use of T-MSIS data to identify, in a timely manner, enrollees who may be deceased. CMS further stated that the Federal-State partnership depends on clear lines of responsibility and shared expectations. CMS specified that States are responsible for accurately determining eligibility for all individuals applying for or receiving benefits, and CMS provides States with guidance and technical assistance to support them in complying with the applicable Federal requirements. CMS indicated that it expects States to operate their Medicaid programs in compliance with Federal

requirements but acknowledged that given the OIG's findings, States may be experiencing challenges in this area.

CMS also provided technical comments on our draft report, which we addressed in the report when appropriate. CMS's comments, excluding the technical comments, are included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we maintain that our recommendations are valid. We commend CMS for the actions it has taken to work with States to close the recommendations contained in our 14 prior audits. However, we disagree with CMS's request to remove the first two recommendations, as there are still actions that CMS needs to take to collect the remaining $41 million in unallowable payments and to implement the remaining eight unimplemented recommendations.

Regarding our third recommendation, we agree that States have access to several data sources, in addition to the DMF, that may be used to obtain information about enrollees who may be deceased. However, we disagree with CMS's statement that developing a process to match enrollment data in T-MSIS with the DMF for monitoring purposes could prove redundant, inefficient, and confusing to States. To clarify, we do not intend for the proposed process to replace those State processes already established. States should continue to use available Federal and State data sources to identify individuals enrolled in Medicaid who may be deceased. Our recommendation is that CMS develop a more targeted process to provide technical assistance to States on this issue. CMS could routinely match T-MSIS data with the DMF to identify States that are at high risk of making improper payments to MCOs on behalf of deceased enrollees. And as needed, CMS would then provide high-risk States with additional technical assistance to collect and prevent improper payments. CMS indicated that it expects States to operate their Medicaid programs in compliance with Federal requirements but acknowledged that the findings contained in our prior 14 audits indicate that multiple States have not complied with those requirements. These 14 prior audits demonstrate that additional action is needed to ensure that States can identify and fix issues related to these improper payments. Although we agree that States have the primary responsibility for addressing the improper payments, CMS is best positioned to assess the ongoing risk of these improper payments across States using T-MSIS data that it already collects. Finally, we believe such an approach would enhance the integrity of the Medicaid program and is consistent with CMS's CMIP.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our prior 14 audits covered 450,562 Medicaid capitation payments totaling $318,167,200 that States made to MCOs on behalf of deceased enrollees during audit periods ranging from July 1, 2009, through December 31, 2019. We used a combination of statistical sampling and data analytics to select 50,292 Medicaid capitation payments totaling $16,270,039 for review. This audit did not involve the review of any additional Medicaid capitation payments.

In this audit, we summarized the findings of the 14 previous audits and identified actions CMS could take to improve its Medicaid oversight to more effectively identify States that are not adequately preventing unallowable payments from being made to MCOs after enrollees' deaths or identifying and recouping these unallowable payments in a timely manner. In the 14 previous audits, we determined whether the selected Medicaid capitation payments to MCOs were made for periods of service after the enrollees' dates of death.

During our audit, we did not assess the overall internal control structure of CMS or the Medicaid program. Instead, we assessed CMS's internal controls related to its resolution of the audit findings contained in our previous audits of 14 States and its oversight of Medicaid to ensure that States are adequately preventing unallowable payments from being made to MCOs after enrollees' deaths or identifying and recouping these unallowable payments in a timely manner.

We conducted our audit work from December 2020 through June 2023.

METHODOLOGY

To accomplish our audit objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed CMS's policies and procedures specific to identifying and preventing State Medicaid agencies from making MCO payments after enrollees' deaths;
- assessed CMS's internal controls to document CMS's controls in place over the Medicaid programs specific to ensuring that States are sufficiently preventing Medicaid capitation payments from being made to MCOs on behalf of deceased enrollees and its controls over the audit resolution process;
- summarized the audit findings, including the total estimated Medicaid capitation overpayments identified in the 14 previous audits as well as the status of those overpayments (i.e., still outstanding or collected);

- interviewed CMS officials regarding the status of actions taken on the recommendations contained in our previous audits of 14 States;

- reviewed documentation that CMS provided on the status of actions taken in response to the 14 previous audit reports;

- reviewed CMS's audit resolution policies and procedures; and

- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit findings. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED FEDERAL REPORTS

Report Title	Report Number	Date Issued
Kansas Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths	A-07-20-05125	09/2021
North Carolina Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths	A-04-16-00112	09/2020
The New York State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths	A-04-19-06223	07/2020
Michigan Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths	A-05-17-00048	02/2020
The Indiana State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths	A-05-19-00007	01/2020
The Minnesota State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths	A-05-17-00049	10/2019
Georgia Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-04-15-06183	08/2019
Illinois Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-05-18-00026	08/2019
California Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-04-18-06220	05/2019
Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-05-17-00008	10/2018
Wisconsin Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Death	A-05-17-00006	09/2018
Tennessee Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Deaths	A-04-15-06190	12/2017
Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death	A-06-16-05004	11/2017
Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death	A-04-15-06182	11/2016

APPENDIX C: FEDERAL REQUIREMENTS

Criteria

Federal regulation (42 CFR § 433.10) states that the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage, which varies depending on the State's relative per capita income as calculated by a defined formula, with exceptions made for certain situations.

Federal regulation (42 CFR § 400.203) states that Medicaid managed care providers are defined as "any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services."

Federal regulation (42 CFR § 438.2) states that a capitation payment is "a payment the State makes periodically to a contractor on behalf of each [enrollee] enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular [enrollee] receives services during the period covered by the payment."

Federal regulation (42 CFR § 438.2) also defines an overpayment to include any payment made to an MCO by a State to which the MCO is not entitled under Title XIX of the Act. In addition, 42 CFR section 438.3(c)(2) states that capitation payments may only be made by the State and retained by the MCO for Medicaid-eligible enrollees.

Section 1936(d) of the Act directs the Secretary of Health and Human Services to establish, on a recurring 5-fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combating fraud, waste, and abuse.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 29, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths (A-04-21-09005)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of the Medicaid program. Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program and work closely together to carry out these responsibilities.

The OIG's report summarizes the findings from their prior audits of 14 states, where they found that each state had made Medicaid capitation payments to Managed Care Organizations (MCOs) on behalf of deceased enrollees. Following the issuance of these 14 state audit reports, CMS has worked closely with the states to ensure that the majority of the OIG's recommendations are implemented, and that the identified overpayments are refunded to the federal government. As of July 2023, 50 of the OIG's 60 recommendations have been fully implemented by states, and approximately $126 million has been refunded to the federal government.

The federal-state partnership, central to the success of the Medicaid program, depends on clear lines of responsibility and shared expectations. States are responsible for accurately determining eligibility for all individuals applying for, or receiving, benefits, and CMS provides states with guidance and technical assistance to support them in complying with the applicable federal requirements.[1] For example, CMS provides technical assistance to states in the development and review of their eligibility verification plans to ensure that their verification practices are in accordance with regulations. As part of this review, CMS discusses the states' verification policies, available data sources, and implementation plan with the states. While states must access the data sources identified in their verification plan, they have discretion in determining which electronic data sources are useful for verifying different eligibility criteria.[2] The OIG's report focuses on the use of the Social Security Administration's (SSA) Death Master File

[1] 42 CFR § Part 435 and, if applicable, 42 CFR § 435.119
[2] 42 CFR § 435.945(j)

(DMF), however, this is just one of several data sources that states may use to obtain information about enrollees who may be deceased. For example, states may also use SSA's s State Verification and Exchange System (SVES), State Online Query (SOLQ), Beneficiary and Earnings Data Exchange (BENDEX), and State Data Exchange (SDX). States can also access information regarding enrollees who may be deceased from their state department of health and office of vital statistics. Across the OIG's 14 prior audits, the majority of states were accessing data from at least one of these sources, with several states utilizing three or more. Additionally, per regulations at 42 CFR 435.952(d), states may not deny or terminate eligibility for any individual on the basis of information obtained from data sources in accordance with 435.940 through 435.960 unless the agency has sought additional information from the individual.

Further, CMS regulations at 42 CFR 438.3(c)(2) clarify that capitation payments may only be made by the state, and retained by MCOs, for Medicaid-eligible enrollees. Capitation payments are developed based on the services and populations that are authorized for Medicaid coverage under the state plan, which would not include enrollees who are deceased or are otherwise no longer Medicaid-eligible. CMS requires that states have clear language in their MCO contracts to ensure that all applicable federal requirements are addressed, including those described in 438.3(c)(2) and 438.608(a)(3). In an effort to provide transparency on the criteria used for contract approvals, and to help states verify that their contracts with Medicaid MCOs meet all CMS requirements, CMS has provided states with a detailed guide outlining the contract review and approval process.[3]

CMS is committed to ensuring proper oversight of the Medicaid program and plans to continue ongoing work with states to strengthen Medicaid program integrity efforts. CMS expects that states operate their Medicaid programs in compliance with federal requirements. However, given the OIG's findings in this report, states may be experiencing challenges in this area. CMS takes these findings seriously and appreciates the OIG's review in this area, as they indicate that further review by CMS may be warranted. As noted in the OIG's report, the Comprehensive Medicaid Integrity Plan, released in June 2020, sets forth CMS's strategy to safeguard the integrity of the Medicaid program during federal fiscal years (FYs) 2019–2023.[4] This 5-year plan includes new and enhanced Medicaid program integrity initiatives that build upon existing program integrity efforts, including the utilization of advanced analytics and other innovative solutions to both improve Medicaid eligibility and payment data and maximize the potential for the data to be used for program integrity purposes.

OIG's recommendations and CMS's responses are below.

OIG Recommendation

Collect the outstanding unallowable payments totaling the estimated $41,003,804 we previously identified.

CMS Response

[3] CMS, State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval. January 18, 2022. Accessed at: https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf

[4] CMS, Comprehensive Medicaid Integrity Plan for Fiscal Years 2019 – 2023. Accessed at: https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

CMS regularly provides the OIG updates on the status of recommendations and will continue to work with states to ensure the remaining federal share of unallowable payments is refunded. As noted above, CMS has worked closely with all 14 states to ensure that the OIG's recommendations are implemented as appropriate. At this time, approximately $126 million has already been refunded to the federal government, which demonstrates that CMS is committed to working with states to collect the unallowable payments identified by the OIG as soon as possible.

Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program, and work together closely to carry out these responsibilities. One of the roles that CMS plays in this federal-state partnership is to promote the fiscal integrity of the Medicaid program through the audit resolution process. As it relates to individual state audits, CMS's role includes resolving and monitoring the implementation of recommendations resulting from audits of state Medicaid agencies. The audit resolution process also includes clearing the audit recommendations within six months of issuance of the final audit report, monitoring and verifying implementation of the audit recommendations, and initiating the disallowance process as necessary. CMS has well established and documented processes and procedures for working with state Medicaid agencies throughout the audit resolution process. CMS will continue to follow these standard operating procedures in working with states to ensure the remaining federal share of unallowable payments is refunded.

Given the work CMS has done, and will continue to do, with the states to close these recommendations, we request OIG remove this recommendation.

OIG Recommendation

Ensure that States complete actions on our remaining recommendations to address the internal control weaknesses we identified.

CMS Response

CMS regularly provides the OIG updates on the status of recommendations and will continue to work with states to implement the remaining 10 recommendations. As noted above, CMS has worked closely with all 14 states to ensure that the OIG's recommendations are implemented as appropriate. At this time, 83% of the recommendations from the prior OIG audits have already been implemented, which demonstrates that CMS is committed to working with states to close out these recommendations as soon as possible.

Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program, and work together closely to carry out these responsibilities. One of the roles that CMS plays in this federal-state partnership is to promote the fiscal integrity of the Medicaid program through the audit resolution process. As it relates to individual audits of state's Medicaid programs, CMS's role includes resolving and monitoring the implementation of recommendations resulting from these audits of state Medicaid agencies. The audit resolution process also includes clearing the audit recommendations within six months of issuance of the final audit report, monitoring and verifying implementation of the audit recommendations, collecting unallowable federal dollars improperly claimed and initiating the disallowance process as necessary. CMS has well established and documented processes and procedures for working with state Medicaid agencies throughout the audit resolution process. CMS will continue to

follow these standard operating procedures in working with states to implement the remaining 10 recommendations.

Given the work CMS has done, and will continue to do, with the states to close these recommendations, we request OIG remove this recommendation.

OIG Recommendation

Continue to explore opportunities for using T-MSIS and SSA's DMF data to improve its oversight of the Medicaid program. Specifically, CMS should develop a process to match enrollment and payment information in T-MSIS with the DMF and provide the results of that match to States to help reduce Medicaid capitation payments made to MCOs on behalf of deceased enrollees.

CMS Response

CMS non-concurs with this recommendation. CMS appreciates the information provided in the OIG's report as it indicates that additional action by CMS may be warranted. However, CMS has concerns with the recommendation as written, and requests that the OIG update the recommendation language so that it can be actionable for CMS. Specifically, CMS requests that the recommendation be updated to focus on providing guidance to states that helps them better understand how to use the DMF to identify individuals enrolled in Medicaid who may be deceased.

Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program and work closely together to carry out these responsibilities. States, as the direct administrators of their programs, are responsible for conducting accurate and timely eligibility determinations, and following up with enrollees regarding potential changes in circumstance, if needed.

As noted above, states already have access to several data sources that may be used to obtain information about enrollees who may be deceased. For example, in addition to SSA's DMF, states may also use SSA's SVES, SOLQ, BENDEX, and SDX. The 14 states in the OIG's prior audits were accessing data from at least one of these sources, with several states utilizing three or more. The addition of T-MSIS monitoring could prove redundant, inefficient, and confusing to states. Additionally, the time lag associated with T-MSIS file submission presents potential challenges for the utilization of T-MSIS data to identify, in a timely manner, enrollees who may be deceased. As of July 2023, all 50 states, the District of Columbia, the Virgin Islands and Puerto Rico are producing and submitting T-MSIS data monthly to CMS, but the data for a given month is typically not complete until three months following the end of that month.

Further, in the previous audits of 14 individual states, OIG often identified issues resulting from human and system errors, as well as a lack of internal state processes and procedures to ensure that alerts and other notifications were reviewed and processed on a timely basis. These issues are unlikely to be resolved by providing states with a new data source.