U.S. Government Accountability Office

Medicaid Managed Care: Improper Payment Estimate

GAO-25-107770
Q&A
Report to the Subcommittee on Legislative Branch, Committee on Appropriations, House of Representatives
June 26, 2025

Why This Matters

Improper payments are payments that should not have been made, that were made in an incorrect amount, or whose appropriateness cannot be determined due to lacking or insufficient documentation. They have been a long-standing and significant problem in the federal government. The Payment Integrity Information Act of 2019 (PIIA) requires federal agencies to manage improper payments by, among other things, estimating and reporting on such payments in programs and activities that the agency has determined are susceptible to significant improper payments.

The Centers for Medicare & Medicaid Services (CMS) develops an improper payment estimate for Medicaid, a federal-state health financing program for certain low-income and medically needy individuals. This estimate consists of three components: managed care, fee-for-service, and eligibility.

State Medicaid programs predominantly rely on managed care to provide coverage. In 2022, managed care represented 58 percent of Medicaid spending, and just over 75 percent of Medicaid beneficiaries (about 74 million beneficiaries) received coverage through managed care. Under Medicaid managed care, states contract with managed care plans and generally pay them a fixed monthly amount per beneficiary—a capitation payment—to provide a set of covered services. Managed care plans are then responsible for paying providers for services delivered to beneficiaries and assume the financial risk if the cost of providing these services exceeds the fixed payment for the services. In contrast, under Medicaid fee-for-service, states pay individual health care providers directly for each service delivered.

CMS's improper payment estimate for Medicaid managed care has been at or near 0 percent in recent years, meaning CMS found few to no errors in the payments states made to their Medicaid managed care plans. However, we have previously reported that the improper payment estimate does not account for all program integrity risks related to Medicaid managed care payments.

House Report 117-389, which accompanied the Legislative Branch Appropriations Act, 2023, includes a provision for us to provide quarterly reports on improper payments. In this 10th quarterly report, we describe how CMS develops the improper payment estimate for Medicaid managed care and its other oversight efforts to identify program integrity risks related to Medicaid managed care.

Key Takeaways

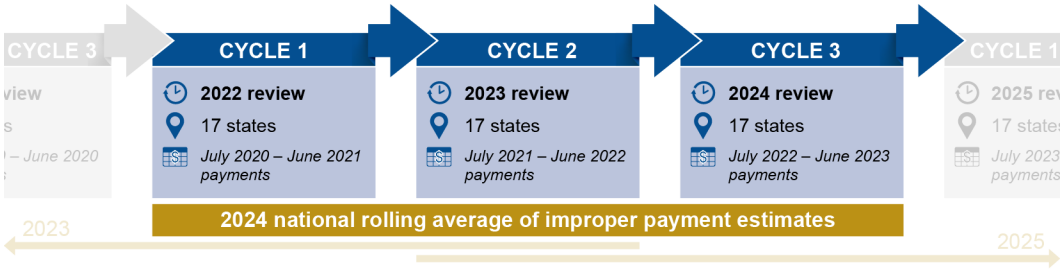
- CMS develops the improper payment estimate for Medicaid managed care by reviewing a sample of the payments that states made to their Medicaid managed care plans. It checks to see if those payments were made correctly based on the information in the state's Medicaid information system and managed care plan contract.

- We and others have identified program integrity risks that are not accounted for in the Medicaid improper payment estimate. These include payments from managed care plans to providers for services that were not provided or lacked necessary documentation.
- To identify program integrity risks not captured in the improper payment estimate, and due at least in part to a prior recommendation from us, CMS increased its audits of managed care plans and providers. As a result of these audits, CMS officials told us the agency has identified over $33 million in overpayments; nearly $23 million of these overpayments are the federal share, which the agency is working to recover.

How does CMS develop the improper payment estimate for Medicaid?

CMS, the federal agency within the Department of Health and Human Services (HHS) that oversees Medicaid and Medicare, develops the improper payment estimate for Medicaid through the Payment Error Rate Measurement (PERM) program.[1] CMS conducts the PERM across all states on a 17-state, 3-year rotational cycle, so that one-third of states are reviewed each year.[2] CMS then computes the national estimate using a rolling average of the improper payment estimates from the most recent 3 years of data. As shown in figure 1, the national Medicaid improper payment estimate reported in 2024 is based on reviews conducted in 2022, 2023, and 2024. The reviews conducted in those years include payments that states made from July 2020 through June 2023.

Figure 1: Review Time Frames Included in the Improper Payment Estimate for Medicaid Reported in 2024



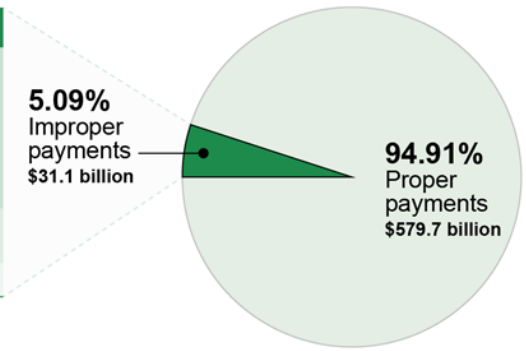
Source: GAO presentation of Department of Health and Human Services information; GAO (illustrations). | GAO-25-107770

Note: The improper payment estimate for Medicaid is developed through the Payment Error Rate Measurement program, and the three cycles encompass all 50 states and the District of Columbia. Future reviews will also include Puerto Rico.

The improper payment estimate for each of the three components—managed care, fee-for-service, and eligibility—is developed under its own methodology within the PERM.[3] Figure 2 shows what each Medicaid component measures and the associated improper payment estimates reported in 2024.

Figure 2: Components of the Improper Payment Estimate for Medicaid and Estimates Reported in 2024

Managed care	Fee-for-service	Eligibility
Measures errors in payments states make to plans on behalf of managed care beneficiaries.	Measures errors in payments states make to providers on behalf of fee-for-service beneficiaries, including payments made to ineligible providers.	Measures errors in state eligibility determinations for both fee-for-service and managed care beneficiaries.
0.00% improper payments	**4.83%** improper payments	**3.31%** improper payments
$0.0 billion	**$11.2 billion**	**$20.2 billion**



Source: GAO and Department of Health and Human Services (HHS) data. | GAO-25-107770

Note: These components are part of the Payment Error Rate Measurement program, which identifies improper payments in Medicaid. The overall Medicaid improper payment estimate is a weighted sum of the managed care, fee-for-service, and eligibility components, with a correction factor so that payments that are improper in

more than one of those components are not double counted. Therefore, the component estimates do not add up to 5.09 percent or $31.1 billion. Amounts reflect the federal share of estimated improper payments and do not include the nonfederal share.

What types of payments does CMS review in the PERM to identify managed care improper payments?

In the PERM, and to be consistent with PIIA, CMS reviews federal Medicaid payments to determine whether they were correct.[4] Federal Medicaid payments are payments for which states can claim federal Medicaid matching funds.[5] CMS determined that for managed care, federal payments are the payments that states make to the managed care plans. In addition, CMS's review under the managed care component of the PERM includes only risk-based payments—payments for which the managed care plan holds the risk for any potential financial gains or losses.[6] Risk-based payments to managed care plans include:

- **Capitation payments:** These are fixed, periodic (generally monthly) payments approved by CMS that state Medicaid agencies make to managed care plans to cover the provision of medical services to beneficiaries, as well as plans' administrative expenses and their profits or earnings. The payment amount, or capitation rate, is developed by states for subgroups of beneficiaries with similar cost characteristics. These subgroups, or rate cells, are generally based on demographic factors such as beneficiary age, gender, geographic location, and eligibility group.
- **Supplemental negotiated rate payments:** These are payments that states make to managed care plans on behalf of a particular beneficiary for specific conditions. These payments can cover multiple services and thus the managed care plan retains the financial risk for providing the covered services. For example, states may provide a managed care plan a maternity payment (sometimes called a "kick payment") that is in addition to a regular capitation payment for a beneficiary who is pregnant to cover services related to childbirth and newborn care.

CMS reviews these payments to determine whether they were made in the correct amount based on documentation in the state's Medicaid information system and the terms of the managed care plan contract. In the state Medicaid information system, CMS reviews beneficiary demographic information that was used in determining the rate cell to which the beneficiary was assigned. The purpose of reviewing beneficiary information as part of the managed care component of the PERM is not to confirm the accuracy of the beneficiary's eligibility determination, because CMS assesses this in the eligibility component of the PERM. Rather, the purpose of the review is to allow CMS to confirm that the capitation payment was correct based on the beneficiary information in the state's system at the time of payment.

CMS also looks at the terms of the managed care plan contract, including the specified capitation rates, to confirm whether the payment under review was made in the correct amount. For example, if a managed care plan contract specifies a certain capitation rate for children between the ages of 6 and 14 who are living in a certain region of the state, then CMS would check that the information in the state's Medicaid system showed that the beneficiary for which the payment was made was between 6 and 14 years old and lived in the specified part of the state. CMS would also check that the payment made was for the amount specified in the contract. See table 1 for steps CMS takes to determine whether states paid the correct amount as part of the PERM.

Table 1: Medicaid Managed Care Component Review Steps in the PERM	
CMS review step	**Examples of data reviewed from the state's Medicaid information system or managed care plan contract**
Determine whether payment was made in accordance with beneficiary information as shown in the state's Medicaid information system at the time of payment.	Beneficiary information, including date of birth or death, citizenship status, city/zip code, beneficiary identification number, living arrangements (home or facility), and other information.
Determine whether beneficiary was enrolled in the managed care plan.	Health plan information, including health plan name, number, and beneficiary enrollment.
Determine whether the payment amount was correct and if any duplicate payments were made within the state.	Terms of the health plan contract, including capitation rates in effect for the coverage month, and the population, services, and geographic areas covered.

Source: GAO review of documentation from the Centers for Medicare & Medicaid Services (CMS). | GAO-25-107770

Note: These review steps are part of CMS's Payment Error Rate Measurement (PERM) program, which identifies improper payments in Medicaid.

Because the PERM focuses only on federal payments to managed care plans, CMS does not review payments from plans to providers, such as payments to doctors and hospitals for services delivered. CMS officials told us this is because payments from plans to providers—unlike payments from states to managed care plans—are not subject to a direct federal match and thus do not meet the definition of payments subject to PIIA. CMS officials also noted that payments from plans to providers are between two non-federal entities and thus they do not count as federal payments for purposes of the PERM.

Does CMS's estimate of improper payments in Medicaid managed care include the same types of payments as its estimate of improper payments in Medicare's managed care program?

In general, CMS reviews the same types of payments in developing its improper payment estimates for both Medicaid managed care and Medicare's managed care program, known as Medicare Advantage.[7] For both, the improper payment estimate includes the payments made to managed care plans and a determination of whether they were correct. In addition, for both Medicaid managed care and Medicare Advantage, the improper payment estimate does not measure the accuracy or appropriateness of payments that managed care plans made to providers. For example, neither estimate looks at whether services were medically necessary or actually delivered.

However, given the differences in the payment structures for the two managed care programs, CMS reviews different information to identify errors in each program's payments to managed care plans. For Medicare Advantage, CMS reviews medical records submitted by the plans for a sample of enrolled beneficiaries and determines whether there is adequate documentation to support beneficiary diagnoses. This is because beneficiary diagnoses, which are submitted by plans, are the primary component used to adjust the payments made to the Medicare Advantage plans.[8] For example, the amount paid to a Medicare Advantage plan for a beneficiary may be based on a diagnosis of diabetes with complications. In that case, CMS reviews the submitted medical records for documentation of complications related to diabetes, such as cardiovascular disease or chronic kidney disease. If the plan cannot submit such documentation, the diagnosis submitted by the plan may be inaccurate and would result in errors in the payments to the Medicare Advantage plan.

For Medicaid managed care, CMS reviews data in state information systems to determine whether the payment made to the managed care plan was made in the correct amount according to beneficiary demographic information (e.g., age, gender, geographic location, and eligibility group) and plan contract and coverage requirements. CMS does not review medical records to identify errors in the payments to Medicaid managed care plans because those payments are generally not based on diagnoses.

CMS found a higher rate of errors in payments for Medicare Advantage than in Medicaid managed care, possibly due, at least in part, to the different payment

structures in the two programs. Specifically, the improper payment estimate reported in 2024 for Medicare Advantage was 5.61 percent, compared to 0 percent for Medicaid managed care.[9]

What are examples of Medicaid managed care payment errors that would be captured by the PERM?

There are various errors that the PERM would capture during the review of Medicaid managed care payments from states to managed care plans. Payment errors occur when states make payments to managed care plans that should not have been made or were in amounts different than what states were contractually required to pay. Examples include the following:

- A capitation payment that should not have been made based on beneficiary information in the state Medicaid system at the time of payment. This could include, for example, a capitation payment made for an individual who, according to the state Medicaid information system, was incarcerated or deceased at the time of payment.[10]
- A capitation payment that was made in an amount different than what the managed care plan contract specified for the beneficiary's demographic characteristics.
- A capitation payment that was made in the incorrect amount because the beneficiary was assigned to the wrong rate cell.
- Duplicate capitation payments made by the state for the same beneficiary identification number for the same month.

What program integrity risks related to Medicaid managed care payments are not captured by the PERM?

Our prior work, as well as prior work by the HHS Office of Inspector General (HHS-OIG) and some state auditors, has identified multiple examples of program integrity risks related to Medicaid managed care payments that are not captured in the managed care component of the PERM. For example, we previously reported that CMS's Medicaid improper payment estimate for managed care does not include all program integrity risks. Specifically, the estimate does not include payments from managed care plans to providers or unallowable managed care costs, such as certain marketing costs, that are included in the data used to establish capitation rates.[11] In addition, HHS-OIG and some state auditors have reported that states have made capitation payments on behalf of Medicaid beneficiaries who were concurrently enrolled in managed care plans in two or more states.[12] In this work, HHS-OIG and state auditors have examined additional information, such as interstate beneficiary enrollment files and claims data, to identify program integrity risks that fall outside the scope of the managed care component of the PERM.

Table 2 shows examples of program integrity risks related to Medicaid managed care payments that would not be captured by the PERM. As shown, these can be broadly categorized into two areas: (1) state capitation payments to Medicaid managed care plans that may be inappropriate based on information that was not evident in the state data reviewed in the PERM, and (2) potentially inappropriate payments from Medicaid managed care plans to providers.

Table 2: Examples of Program Integrity Risks in Medicaid Managed Care Payments Not Captured by the PERM

Program integrity risk	Example
State payments to Medicaid managed care plans that may be inappropriate based on information not evident in the state data reviewed in the PERM	
Capitation payments for the same beneficiary assigned multiple identification numbers	In 2021, Ohio state auditors reported that the state made 61,852 capitation payments to managed care plans on behalf of beneficiaries assigned two or more Medicaid identification numbers. This resulted in approximately $14.5 million in duplicate capitation payments that had not been recovered by the state at the time of the audit.
Capitation payments for beneficiaries concurrently enrolled in more than one state	A 2024 report from Oregon state auditors found that the state paid about $445 million in capitation payments for Medicaid beneficiaries enrolled in Oregon and one or more other states. For example, between 2019 and 2022, Oregon paid $134 million on behalf of beneficiaries who were also enrolled in California's Medicaid program and $65 million on behalf of beneficiaries also enrolled in Washington state.
Capitation payments for deceased beneficiaries with date of death not recorded in the state's Medicaid information system	In 2023, the Department of Health and Human Services' Office of Inspector General (HHS-OIG) reported that it identified more than $249 million in unallowable capitation payments made by 14 states on behalf of deceased Medicaid beneficiaries. HHS-OIG found that 11 states did not consistently identify and process beneficiaries' death information. In addition, HHS-OIG found nine states did not enter dates of death into the state's Medicaid information system.
Potentially inappropriate payments from Medicaid managed care plans to providers	
Payments to ineligible providers	A 2023 report from Louisiana state auditors found that, for the fifth consecutive year, the state did not screen managed care providers nor check whether any were excluded from participating in federal programs as required by federal law. As a result, auditors could not determine what portion of the 96 million claims totaling $7.5 billion paid to managed care providers in 2022 went to ineligible providers.
Payments for services not delivered, lacking required documentation, or in incorrect amounts	In 2020, Florida state auditors reported that managed care plans paid 27,316 managed care prescription claims for controlled substances between July 2017 and March 2019 that did not appear to adhere to state law requiring documentation showing physician or hospital visits with the beneficiary at least quarterly during treatment.
Payments for services duplicative of those delivered by another provider or in another setting	In 2020, Florida state auditors reported that managed care plans paid providers $222,732 in managed care claims between July 2017 and March 2019 for 826 home health visits that were recorded on the same date that the beneficiary had a claim paid for an inpatient stay. The auditors noted that this suggested that payments may have been made for duplicative services.

Source: GAO analysis of documentation from the HHS-OIG and selected state auditors. | GAO-25-107770

Note: The Centers for Medicare & Medicaid Services' Payment Error Rate Measurement (PERM) program identifies improper payments in Medicaid. Examples in the table are from our review of state auditor reports in five selected states—Florida, Louisiana, Ohio, Oregon, and Pennsylvania—for fiscal years 2021 through 2024. According to our review, Pennsylvania state auditor reports during this period did not identify program integrity risks related to Medicaid managed care payments.

What oversight activities outside of the PERM has CMS conducted to identify program integrity risks related to Medicaid managed care payments?

In addition to the PERM, CMS has conducted various oversight activities to identify program integrity risks in Medicaid managed care payments. These efforts, which CMS officials told us they have increased partially in response to recommendations from GAO and the HHS-OIG, include audits of managed care providers and plans, as well as state program integrity reviews.

- **Provider audits** review a sample of payments made by one or more Medicaid managed care plans to a selected provider in the plan's network to identify and report payments that should not have been made or were made in incorrect amounts. These include payments for services that were not provided or lacked necessary documentation. Between October 2021 and February 2025, CMS completed 899 provider audits and found examples of overpayments in varying amounts. For example, one audit identified around $1,600 in overpayments made by a managed care plan to a children's hospital that were not returned within the time period required by federal law.[13] Another audit identified over $960,000 in overpayments to a hospice that did not respond to multiple requests for documentation for services covered by three managed care plans.
- **Managed care plan audits** review a sample of payments to and from a managed care plan in a selected state, including capitation payments from the state to the managed care plan and payments from the plan to providers.

CMS officials told us that they first piloted this approach in 2020, selecting all three Medicaid managed care plans in one state. Findings identified program integrity issues such as state capitation payments to managed care plans for deceased beneficiaries and managed care plan payments to providers who failed to provide proper documentation for services or have been excluded from participating in the Medicaid program.[14] For example, one audit found that the state made capitation payments to a managed care plan on behalf of 638 beneficiaries up to 18 months after their date of death, resulting in potential overpayments totaling over $370,000 over a 2-year period. According to CMS, since 2023, the agency has expanded this work to other states, opening 155 managed care plan audits, nearly all of which remain open.[15]

- **State program integrity reviews focused on managed care** assess selected states' compliance with federal and contract requirements for overseeing managed care plans. Since October 2021, CMS has published reviews focused on managed care oversight in 23 states. Program integrity issues identified include opportunities for states to strengthen language in managed care plan contracts to comply with federal requirements regarding overpayments and improve state monitoring of payments recovered from managed care plans.[16]

CMS officials told us that, between October 2021 and February 2025, 243 audits identified over $33 million in overpayments to Medicaid managed care plans and providers; nearly $23 million of that is the federal share. According to CMS, as of February 2025, the agency has recovered more than $6 million of the federal share of these overpayments.

CMS officials told us they have used findings from these oversight activities to refine their oversight strategy, increase audit activities focused on managed care, create training materials for state Medicaid agencies, and develop policies to strengthen program integrity in Medicaid managed care. For example, CMS officials told us the provider audits routinely resulted in findings. However, these audits look at plan payments only to a single provider. CMS determined it would be impactful to also conduct reviews at the managed care plan level. As a result, since 2023, CMS has increased the number of managed care plan audits it conducts.

In addition, CMS officials told us that findings from state program integrity reviews led them to strengthen certain provisions for managed care plan reporting of overpayments to states. For example, in a 2024 final rule, CMS required state managed care plan contracts to include a provision for plans to report all overpayments identified or recovered on an annual basis and clarified the time frame for reporting identified overpayments to states.[17] According to CMS, this will ensure states have timely information to remove these payments from the data used to calculate future capitation rates, which would otherwise be inflated.[18]

What actions could CMS take to strengthen Medicaid program integrity and fiscal stewardship?

We have made several recommendations to CMS to strengthen Medicaid program integrity and fiscal stewardship that remain unimplemented. These include the following:

- **Enhancing the effectiveness of Medicaid recovery audits.** CMS should conduct a cost-effectiveness study to determine whether states should include payments to managed care plans as part of the recovery audit program.[19] The recovery audit program, which is implemented by states, is intended to identify overpayments and underpayments, and recover overpayments.

- **Leveraging findings from and improving collaboration with state auditors**. CMS should use trends in state auditor findings to inform its oversight and share information on those trends and the status of actions to address findings with state auditors.[20]
- **Collecting better data on Medicaid payments.** CMS should collect data from states on the source of funds used to finance the nonfederal share of state Medicaid payments.[21]

In addition, the HHS-OIG has made recommendations to CMS to leverage Medicaid data that the agency receives from states to improve Medicaid program integrity. For example, they recommended that CMS provide states with data that identifies Medicaid beneficiaries who were concurrently enrolled in Medicaid managed care in two states and assist states with using this data to reduce future capitation payments.[22] Similarly, the HHS-OIG recommended that CMS develop a process to match Medicaid data with the Social Security Administration's Death Master File and provide this data to states to help reduce Medicaid payments made to managed care plans for individuals who are deceased.[23]

In addition to these recommendations, we recommended that Congress consider taking action to improve Medicaid's fiscal stewardship. In particular, Congress could consider requiring increased attention by CMS to help ensure that states' Medicaid demonstration projects—projects intended to test or evaluate new initiatives or approaches for delivery of Medicaid services—are fiscally responsible. This could include requiring CMS to more clearly outline the methods used to determine whether these demonstration projects are budget neutral to the federal government.[24] Demonstrations are budget neutral if the federal government will spend no more under the demonstration than it would have without the demonstration.

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments, which we incorporated as appropriate.

How GAO Did This Study

To understand how CMS developed the improper payment estimate for Medicaid managed care, we reviewed relevant federal statutes and regulations, as well as agency documentation such as CMS's PERM Manual and HHS's Agency Financial Reports. We also reviewed documentation on CMS's methodology for determining improper payments for Medicare Advantage, and we interviewed CMS officials for additional information on both methodologies.

To describe program integrity risks related to Medicaid managed care payments that are not captured by the PERM, we reviewed our past reports in this area, as well as reports by the HHS-OIG and state auditors in five selected states. We selected these states—Florida, Louisiana, Ohio, Oregon, and Pennsylvania—to achieve variation in geographic location and size of the Medicaid managed care population. For each of the selected states, we reviewed (1) the two most recent single audits, and (2) standalone reports issued by the state auditor from fiscal years 2021 through 2024. We also reviewed documentation related to CMS's oversight activities, including findings from its audits of managed care plans and providers. Finally, we interviewed officials from CMS, the HHS-OIG, and an organization that represents state auditors.

We conducted this performance audit from August 2024 to June 2025 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.

List of Addressees

The Honorable David Valadao
Chairman
The Honorable Adriano Espaillat
Ranking Member
Subcommittee on Legislative Branch
Committee on Appropriations
House of Representatives

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

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Endnotes

[1]An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. 31 U.S.C. § 3351(4). When an executive agency's review is unable to discern whether a payment was proper because of insufficient or lack of documentation, this payment must also be included in the improper payment estimate. 31 U.S.C. § 3352(c)(2).

Improper payments and fraud are distinct concepts that are not interchangeable, but are related. While all fraudulent payments are considered improper, not all improper payments are due to fraud. See GAO, *Improper Payments and Fraud: How They Are Related but Different*, GAO-24-106608 (Washington, D.C.: Dec. 7, 2023).

Medicare is the federal health insurance program for people aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Similar to Medicaid, CMS estimates improper payment rates for Medicare, including for Medicare's managed care program, also known as Medicare Advantage.

[2]CMS uses federal contractors to carry out the reviews under the PERM.

[3]CMS compiles a universe of federally matched Medicaid payments, including both fee-for-service claims and managed care payments, for each state. CMS then selects a sample of payments to review for errors that lead to improper payments. The sample for the eligibility component is selected from a subset of the sampled fee-for-service claims and managed care payments.

[4]As defined by PIIA, the term "payment" means any transfer or commitment for future transfer of federal funds such as cash, securities, loans, loan guarantees, and insurance subsidies to any non-federal person or entity or a federal employee that is made by a federal agency, a federal

contractor, a federal grantee, or a governmental or other organization administering a federal program or activity. 31 U.S.C. § 3351(5).

[5]States and the federal government share in the financing of the Medicaid program, with the federal government matching state expenditures for Medicaid services on the basis of a formula.

[6]Payments for which the state holds the underlying risk for financial gains or losses are typically included in the fee-for-service component of the improper payment rate. This would include payments made to the managed care plan as direct reimbursement for a service that was delivered.

[7]In Medicare Advantage, CMS contracts with private plans and pays them a fixed amount per beneficiary to provide health coverage to Medicare beneficiaries. CMS develops the improper payment estimate for Medicare Advantage through the Medicare Part C Improper Payment Measurement program.

[8]Because beneficiary diagnosis codes are used to adjust the payments made to Medicare Advantage plans, plans have a financial incentive to ensure that all relevant diagnoses are coded, as this can increase the payments that plans receive. The HHS-OIG has studied the sources of diagnoses submitted by plans and found that an estimated $7.5 billion in risk-adjusted payments for 2023 were the result of diagnoses reported only on health risk assessments and chart reviews linked to health risk assessments, and not supported by any other records of services. According to HHS-OIG, this raises concerns that (1) the diagnoses are inaccurate and thus the payments are improper, or (2) enrollees did not receive needed care for serious conditions reported only on health risk assessments and chart reviews linked to health risk assessments. See Department of Health and Human Services, Office of Inspector General, *Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions,* OEI-03-23-00380 (Washington, D.C.: October 2024).

[9]The improper payment estimate reported in 2024 of 5.61 percent for Medicare Advantage represented $19.07 billion.

[10]The Social Security Act generally prohibits the use of Medicaid funds to pay for the health care of an "inmate of a public institution," such as a prison. See 42 U.S.C. § 1396d(a)(32)(A).

[11]See GAO, *Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care*, GAO-18-291 (Washington, D.C.: May 7, 2018).

[12]For example, see Department of Health and Human Services, Office of Inspector General, *Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States*, A-05-20-00025 (Washington, D.C.: September 2022); Oregon Secretary of State Audits Division, *Oregon Health Authority: Without Federal Action, States Will Continue to Pay Millions of Dollars in Duplicate Medicaid Payments* (Salem, Ore.: October 2024). We have ongoing work looking at payments made for duplicate health coverage including for individuals who are enrolled in Medicaid managed care in more than one state.

[13]Overpayments must be reported and returned by the later of 60 days of the overpayment being identified or by the date any corresponding cost report is due, if applicable. See 42 U.S.C. § 1320a-7k(d)(2).

[14]CMS's managed care plan audits identify capitation payments for deceased beneficiaries using information sources that may not be linked to a state's Medicaid information system. For example, states may elect to periodically check external data sources, such as the Social Security Administration's Death Master File, to identify Medicaid beneficiaries who may be deceased, but not all states do so.

[15]According to CMS officials, audits remain open while the agency is collecting, reviewing, and analyzing information. Once the auditor drafts their findings, the state Medicaid agency and managed care plans have a chance to comment and provide additional documentation before the report is finalized and the audit is closed. CMS officials also told us that each managed care plan audit takes about 18 months to complete, and that the state has one year after the audit closes to recover any overpayments and submit the federal share to CMS. See 42 U.S.C. § 1396b(d)(2)(C).

[16]States' contracts with managed care plans must include provisions for plans to implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse. For example, states' managed care contracts must specify the process, time frames, and documentation required to report the recovery of all overpayments. See 42 C.F.R. § 438.608 (2024).

[17]For any capitation rates taking effect on or after July 9, 2025, managed care plans must report all overpayments to the state within 30 calendar days, specifying the overpayments due to potential fraud. 89 Fed. Reg. 41,002, 41,284 (May 10, 2024), amending 42 C.F.R. § 438.608.

[18]States must use information that managed care plans report about all overpayments identified or recovered in order to set actuarially sound capitation rates for each managed care plan. See 42 C.F.R. § 438.608(d)(4) (2024). CMS noted in the preamble to its May managed care final rule that overpayments to providers should be excluded from the capitation rate because they do not

represent reasonable, appropriate, or attainable costs. 89 Fed. Reg. at 41,136.

[19]CMS did not agree with this recommendation. CMS noted that states are permitted to tailor their recovery audit programs to their specific needs and environment, and that states have other ways to oversee managed care improper payments. Given CMS's role in helping ensure that states make Medicaid payments appropriately, we continue to believe that CMS should assess the cost-effectiveness of requiring states to include payments to managed care plans as part of their recovery audit efforts. See GAO, *Medicaid: CMS Oversight and Guidance Could Improve Recovery Audit Contractor Program*, GAO-23-106025 (Washington, D.C.: June 28, 2023).

[20]Since the report was issued, CMS has taken some steps to address these recommendations. For example, CMS began using national trends in findings the state auditors identified to improve audit processes, and CMS has shared information with state auditors on audit trends and program risks. To fully implement these recommendations, CMS should use trends it identifies in state auditor findings to inform the agency's oversight activities. In addition, CMS should demonstrate a pattern of sharing information on audit trends and program risks with state auditors over multiple years. See GAO, *Medicaid Program Integrity: Opportunities Exist for CMS to Strengthen Use of State Auditor Findings and Collaboration*, GAO-23-105881 (Washington, D.C.: Sept. 21, 2023).

[21]CMS neither agreed nor disagreed with our recommendation, but acknowledged the need for additional state Medicaid financing and payment data to oversee the Medicaid program. Although CMS has begun to improve its collection of state payment information, new state reporting does not include information on the source of funds used to finance the nonfederal share of Medicaid payments. To fully implement our recommendation, CMS needs to demonstrate how its ongoing and planned actions in this area will ensure complete, consistent, and sufficiently documented information about the nonfederal sources of funding for all Medicaid payments. See GAO, *Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight*, GAO-21-98 (Washington, D.C.: Dec. 7, 2020).

[22]See Department of Health and Human Services, *Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled*.

[23]See Department of Health and Human Services, Office of Inspector General, *Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths*, A-04-21-09005 (Washington, D.C.: November 2023).

[24]Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. See GAO, *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, GAO-08-87 (Washington, D.C.: Jan. 31, 2008).