Department of Health and Human Services
Office of Inspector General
Office of Audit Services

December 2025 | A-04-23-09010

Medicaid Agencies Made Millions in Unallowable Capitation Payments to Managed Care Organizations on Behalf of Deceased Enrollees

REPORT HIGHLIGHTS

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Medicaid Agencies Made Millions in Unallowable Capitation Payments to Managed Care Organizations on Behalf of Deceased Enrollees

Why OIG Did This Audit

- Since 2016, OIG has conducted 18 audits identifying that Medicaid agencies had improperly made roughly $289 million ($202 million Federal share) in capitation payments on behalf of deceased enrollees.
- The improper payments have drawn the attention of the U.S. Senate Committee on Finance, which has found that States continue to struggle with the issue. Provisions of the recently enacted One Big Beautiful Bill Act (OBBB Act) may help minimize unallowable Medicaid payments made on behalf of deceased enrollees.
- Because of the significant issues identified in our prior audits and ongoing congressional interest, we conducted this audit to estimate the value of Medicaid capitation payments made to managed care organizations (MCOs) on behalf of deceased enrollees.

What OIG Found

- We estimate that Medicaid agencies made $207,501,380 ($138,645,710 Federal share) in unallowable capitation payments to MCOs for enrollees whose date of death, as recorded by the Social Security Administration's Death Master File, occurred before the monthly service periods covered by the capitation payments during our audit period (July 1, 2021, through June 30, 2022).
- This estimate is based on the results of our review of 100 statistically sampled capitation payments. We determined that Medicaid agencies made unallowable capitation payments after enrollees' deaths for 99 of the 100 sample payments. However, for 50 of those unallowable capitation payments, we found that Medicaid agencies recovered the overpayments before we provided them with the sample capitation payments for their review. The remaining 49 capitation payments were either not recovered or recovered after we sent the Medicaid agencies the sample capitation payments for their review. As a result of these unallowable and not previously recovered payments, we estimated $207,501,380 ($138,645,710 Federal share) in unallowable capitation payments for our audit period.

What OIG Recommends

We made two recommendations to CMS: (1) that it provide the Medicaid agencies covered by our audit with our matched T-MSIS data so that those agencies can review the capitation payments and take appropriate action to recover any unallowable payments, and (2) that it explore opportunities to work with Medicaid agencies to ensure that provisions of the OBBB Act are properly implemented. This effort could result in yearly estimated savings of $207,501,380 ($138,645,710 Federal share).

CMS concurred with our first recommendation and did not clearly indicate concurrence or nonconcurrence with our second recommendation. However, CMS described actions that it planned to take to address both recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Department of Health and Human Services (HHS), Office of Inspector General (OIG) has identified minimizing fraud, waste, and abuse in Medicare and Medicaid programs—including preventing Medicaid managed care payments on behalf of deceased enrollees—as a top management and performance challenge facing HHS.[1]

Since 2016, OIG has conducted 18 audits identifying that Medicaid agencies had improperly made capitation payments on behalf of deceased enrollees totaling approximately $289 million ($202 million Federal share).[2] In 2023, OIG issued a report to the Centers for Medicare & Medicaid Services (CMS) summarizing the results of 14 of these reports and recommended that CMS collect the outstanding unallowable payments previously identified and explore opportunities to use Transformed Medicaid Statistical Information System (T-MSIS) data and the Social Security Administration (SSA) Death Master File (DMF) to improve its oversight of the Medicaid program (see Appendix B).

The improper payments have drawn the attention of the U.S. Senate Committee on Finance. In an October 1, 2019, letter to 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] Recently enacted legislation may help minimize unallowable Medicaid payments made on behalf of deceased enrollees.[4]

Because of the significant issues identified in our prior audits and ongoing congressional interest, we conducted this audit to estimate the value of Medicaid capitation payments made to managed care organizations (MCOs) on behalf of deceased enrollees.

OBJECTIVE

Our objective was to determine a nationwide estimate of Medicaid capitation payments made to MCOs on behalf of deceased enrollees.

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[1] OIG, *Top Management & Performance Challenges Facing HHS 2024*.

[2] The audit periods for these 18 audits ranged from 2 to 6 years.

[3] U.S. Senate Committee on Finance, letter to Seema Verma, Administrator, CMS, Oct. 1, 2019. Accessed on June 9, 2025.

[4] H.R.1 - One Big Beautiful Bill Act (OBBB Act), Section 71104. Accessed on July 7, 2025. The Act contains a provision that requires all States and the District of Columbia, beginning January 1, 2027, to check the SSA DMF at least quarterly to determine whether Medicaid enrollees are deceased.

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 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 payment for these services. These payments are called capitation payments, which a State makes periodically to a contractor, such as an MCO, on behalf of each enrollee covered by a contract. The payments are based on an actuarially sound rate for providing 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).

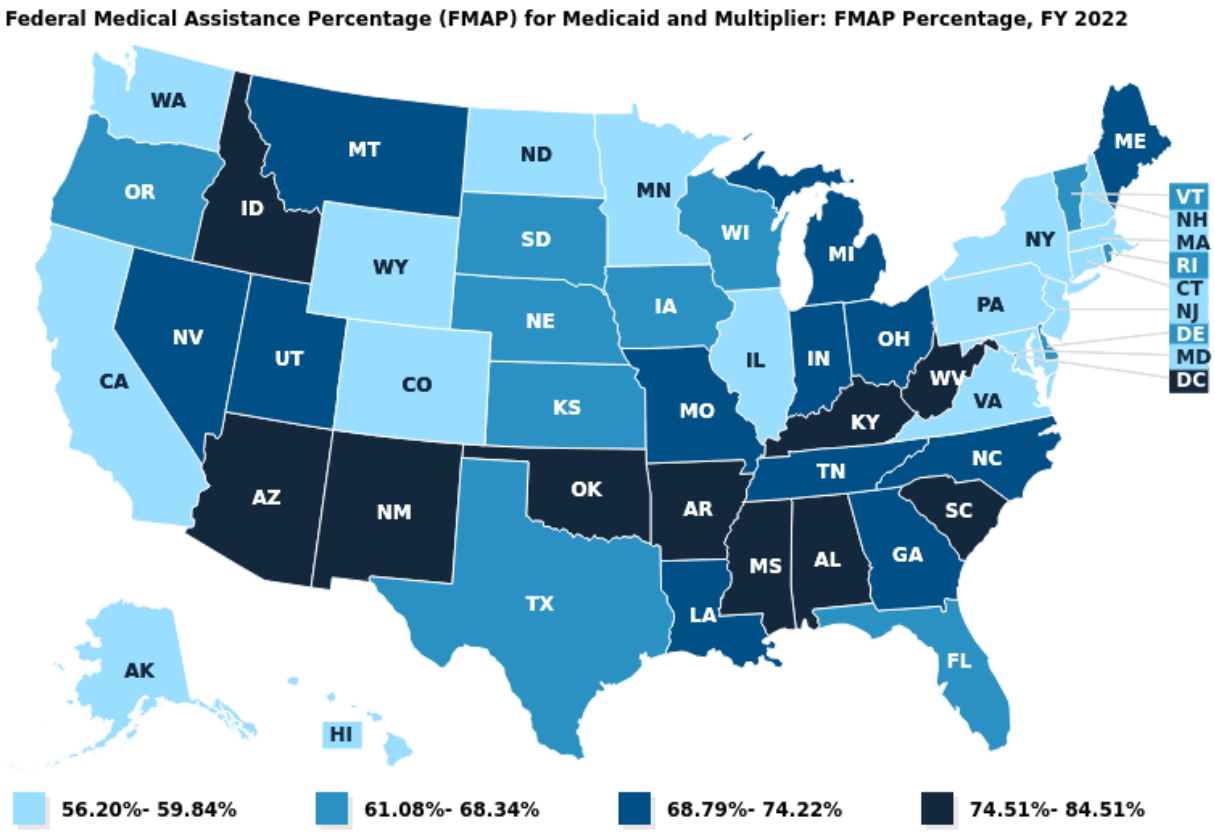
States report capitation payments made to the MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).[5] The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal Medical Assistance Percentage (FMAP), 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. In Federal fiscal year 2022, the FMAP ranged from 56.20 percent to 84.51 percent (see graphic on next page).[6, 7, 8]

[5] Form CMS-64. Accessed on June 9, 2025.

[6] 85 Fed. Reg. 76586. Accessed on June 9, 2025.

[7] The Families First Coronavirus Response Act provided a temporary 6.2-percent FMAP increase applicable during our audit period (July 1, 2021, through June 30, 2022) (87 Fed. Reg. 58456). Accessed on June 9, 2025. The FMAP range listed in the text above includes the 6.2-percent increase.

[8] We did not use the enhanced FMAP for our audit. The enhanced FMAP is a higher Federal percentage used in the Children's Health Insurance Program and in the Medicaid program for expenditures for medical assistance provided to certain individuals.



Social Security Administration's Date of Death Information

SSA obtains death record information from various 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 SSA's Numerical Identification System (NUMIDENT) using information from SSA's Death Information Processing System.[9,10] SSA then

[9] NUMIDENT contains personally identifiable information for individuals who have been issued a Social Security number (SSN). NUMIDENT is SSA's official source of death information. This system automatically sends death information to SSA's payment systems.

[10] SSA, Program Operations Manual System, GN 02602.050, Reports of Death. Accessed on June 9, 2025.

uses the NUMIDENT information to create a database called the DMF.[11] SSA can provide a full file of death information to States through a data exchange agreement.[12]

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

Medicaid's claims processing system, called the Medicaid Management Information System (MMIS), was designed to meet principal objectives, which 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 MMIS stores and maintains data on Medicaid enrollees (e.g., date of birth and date of death), health care services covered, and expenditures.

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; show which services they use; and document payments made for services they received that are covered by State Medicaid programs. In 2011, CMS began working with States to transition from the MSIS to T-MSIS to improve Medicaid data and data analytic capacity. The 50 U.S. States, Puerto Rico, and Washington, DC, use T-MSIS to submit data to CMS.

HOW WE CONDUCTED THIS AUDIT

We reviewed net Medicaid capitation payments[13] (capitation payments) made by Medicaid agencies in 35 States, Puerto Rico, and Washington, DC, (Medicaid agencies)[14] on behalf of enrollees whose deaths preceded the monthly service period covered by the capitation

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[11] SSA maintains death data—including names, SSNs, dates of birth, and dates of death—in the DMF for deceased individuals. The more comprehensive file, called 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.

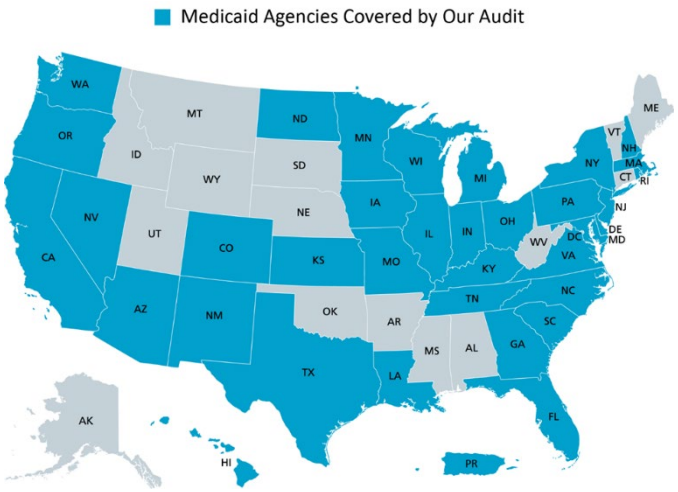
[12] The full file of death information is the DMF, which includes State death records.

[13] For each service month of our audit period, we netted all the capitation payments (i.e., summed the debits and credits) made to one MCO on behalf of a single enrollee.

[14] For the remaining 15 States, we found the following during our audit period: (a) Alaska and Vermont had no capitation payments; (b) Alabama, Arkansas, Idaho, Montana, Oklahoma, and Utah had capitation payments for only limited benefits managed care plans (our audit covered comprehensive managed care plans); (c) Connecticut, Maine, Mississippi, Nebraska, South Dakota, and Wyoming had no capitation payments with a service date after the month of the enrollee's death; and (d) West Virginia identified unallowable capitation payments, but we did not include these payments in our sampling frame because of large discrepancies in capitation payments between T-MSIS and MMIS data.

payment during our audit period (July 1, 2021, through June 30, 2022). Specifically, our audit covered 409,862 capitation payments of $50 or more—totaling $408,465,511 ($263,335,398 Federal share)—that Medicaid agencies made to MCOs and claimed for Federal reimbursement during our audit period. The Medicaid agencies made these payments on behalf of enrollees whose dates of death (DOD), as recorded in one or more of the data sources we consulted, preceded service periods covered by the monthly capitation payment.

We selected for review a stratified random sample of 100 capitation payments totaling $257,547 ($167,357 Federal share) from the 409,862 capitation payments covered by this audit.[15] We provided each Medicaid agency that made a capitation payment in our sample with details of the capitation payment(s) for its review. For each sample item, we requested that the Medicaid agency determine whether the enrollee identifying information, including DOD, was correct; whether a capitation payment occurred for the service month; and whether any adjustments or recoveries were made. We also requested the reason a capitation payment was made on behalf of a deceased enrollee, if applicable. We used the results of this review to estimate the total amount and Federal share of the unallowable capitation payments for payments covered by this audit.



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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix C contains the statistical sampling methodology, Appendix D contains the sample results and estimates, and Appendix E contains the Federal requirements related to State Medicaid capitation payments made to MCOs on behalf of enrollees.

[15] Our 100 sample capitation payments were associated with 27 Medicaid agencies.

FINDINGS

We found that Medicaid agencies made unallowable capitation payments after enrollees' deaths for 99 of the 100 sample capitation payments.[16] However, for 50 of those unallowable capitation payments, we found that Medicaid agencies recovered the overpayments before we provided them with the sample capitation payments for their review.

The remaining 49 capitation payments were either not recovered or recovered after we sent the Medicaid agencies the sample capitation payments for review.[17] These unallowable capitation payments occurred for the following reasons:[18]

- For 29 capitation payments, totaling $25,068 ($17,313 Federal share), the Medicaid agencies' sources of death data did not have the enrollee's DOD.

- For 14 capitation payments, totaling $36,928 ($23,245 Federal share), Medicaid agencies did not have the DOD in MMIS, but the DOD was available through other data sources, such as the State Online Query (SOLQ)[19] or vital statistics offices.[20]

- For 4 capitation payments, totaling $4,936 ($3,158 Federal share), the DOD in MMIS was consistent with the corresponding DOD information in the DMF, but the Medicaid agencies did not update eligibility once these enrollees were identified as deceased.

- For 2 capitation payments, totaling $7,107 ($4,158 Federal share), a Medicaid agency had a DOD for the enrollees that was not consistent with the DOD in the DMF. For both of those payments, the DOD in the MMIS was after the DOD in the DMF. Therefore, the Medicaid agency continued to make payments for these enrollees.

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[16] For one sample capitation payment, we could not confirm that the enrollee was deceased.

[17] Medicaid agencies recovered five sample capitation payments totaling $6,144 ($4,428 Federal share) after we sent them the sample capitation payments for review.

[18] Medicaid agencies provided the reasons these errors occurred. We classified the reasons for errors into four categories based on the documentation the Medicaid agencies provided.

[19] SOLQ is an online version of the State Verification and Exchange System (SVES). SOLQ allows Medicaid agencies to access SSA's SSN verification service and retrieve data on Title II Federal Old-Age, Survivors, and Disability Insurance Benefits, or Title XVI Supplemental Security Income for the Aged, Blind, and Disabled. This access enables Medicaid agency social services and other benefit program personnel to rapidly obtain information they need to qualify individuals for programs.

[20] Vital statistics offices collect and maintain records of births, deaths, marriages, and divorces occurring in their State. The mortality data collected include information such as the deceased's name, date of birth, date of death, cause of death, and place of death.

For all 49 capitation payments, the enrollee's DOD was identified in the DMF, and we verified the enrollee's DOD using the U.S. Department of the Treasury's Do Not Pay (DNP)[21] portal or Accurint.[22]

Extrapolating from those 49 capitation payments that were either not recovered or recovered after we sent the Medicaid agencies the sample capitation payments for their review, we estimate that Medicaid agencies made $207,501,380 ($138,645,710 Federal share) in unallowable capitation payments to MCOs for enrollees whose DOD, as recorded by the DMF, occurred before the monthly service periods covered by the capitation payments during our audit period.

CMS AND LEGISLATIVE ACTIONS TAKEN AFTER OUR AUDIT PERIOD

In 2023, CMS's Unified Program Integrity Contractors conducted audits of five Medicaid agencies that included reviews for capitation overpayments made to MCOs on behalf of deceased Medicaid enrollees. The audits included matching T-MSIS data against the DMF. CMS provided the results of the data matches to the individual Medicaid agencies for further review. CMS also began conducting similar audits in 20 States for 2024 and stated that it continues to assess plans for these audits in 2025.

On April 25, 2024, CMS issued guidance to State Medicaid agencies about the available data sources they could use to better match enrollment and payment data against data on deceased enrollees. This guidance reminded State Medicaid agencies of data sources available to them that included the SSA's State Verification and Exchange System (SVES),[23] the Beneficiary and Earnings Data Exchange (BENDEX),[24] and the National Death Index (NDI).[25]

In addition, starting on January 1, 2027, States and the District of Columbia will be required to use the DMF to conduct quarterly verification to determine whether Medicaid enrollees are

[21] DNP is a free service to agencies that allows them to check various data sources to verify an enrollee's eligibility for payment. The DNP includes death information from multiple sources, such as the full DMF, a database of obituary information, and Department of Defense death data.

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

[23] The SVES is a batch query system that allows States to verify the eligibility of individuals for Social Security benefits. SVES also provides an avenue for States to exchange information with SSA about individuals who are applying for or receiving benefits.

[24] The BENDEX is a batched data exchange available to States under written agreements with SSA. BENDEX provides States with access to a variety of enrollee and earnings data.

[25] The NDI is a national database of death records from participating States and territories. The NDI is maintained by HHS's Centers for Disease Control and Prevention.

deceased.[26] If a State determines, based on the DMF, that an enrollee is deceased, the State shall disenroll the deceased enrollee and discontinue any payments on behalf of the enrollee.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services take the following steps:

- provide the Medicaid agencies covered by our audit with our matched T-MSIS data so that the Medicaid agencies can review the capitation payments and take appropriate action to recover any unallowable payments made on behalf of enrollees whose date of death preceded the monthly service period and not already recovered during their normal review process, which could result in the Medicaid agencies recovering unallowable payments made during our audit period; and

- explore opportunities to work with Medicaid agencies to ensure that the related provisions of the One Big Beautiful Bill Act (OBBB Act) are properly implemented. This effort could result in annual estimated savings of $207,501,380 ($138,645,710 Federal share).

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first recommendation and did not clearly indicate concurrence or nonconcurrence with our second recommendation. However, CMS described actions that it planned to take to address both recommendations. Specifically, CMS stated that it will share OIG's matched T-MSIS data with the Medicaid agencies included in this report and encourage them to review and take appropriate action, including recovering any unallowable payments. CMS also stated that it is committed to working with Medicaid agencies as they prepare to implement P.L. No. 119-21, which requires States to check the SSA's DMF at least quarterly to identify any Medicaid enrollees who are deceased.[27] CMS also provided a technical comment on our draft report. CMS's comments, excluding the technical comment, are included as Appendix F.

[26] OBBB Act, Section 71104. Accessed on July 7, 2025.

[27] P.L. No. 119-21 is also referred to as the OBBB Act.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 409,862 net Medicaid capitation payments of $50 or more totaling $408,465,511 ($263,335,398 Federal share) made by Medicaid agencies to MCOs and claimed for Federal reimbursement on behalf of enrollees whose DOD, as recorded in one or more of the data sources, preceded the monthly service periods that were covered by the capitation payment during our audit period.

We did not assess the overall internal control structure of CMS or the Medicaid program. Instead, we assessed the control activities designed and implemented to prevent and detect capitation payments made to MCOs on behalf of deceased enrollees that CMS established after our audit period. We also reviewed CMS protocols for audits of program integrity activities in Medicaid managed care plans and CMS guidance for identifying deceased Medicaid enrollees, both dated after our audit period.

We conducted our audit work from October 2023 through July 2025.

METHODOLOGY

To accomplish our objective, we took the following steps:

- reviewed applicable Federal laws, regulations, and guidance;
- requested CMS provide any guidance it has given to Medicaid agencies related to the identification of deceased enrollees and information related to audits it has conducted of Medicaid payments to MCOs on behalf of deceased enrollees;
- obtained a T-MSIS database of capitation payments made to MCOs on behalf of Medicaid enrollees for our audit period;
- matched the T-MSIS database to the DMF using enrollee identifying information, such as Social Security number (SSN), first and last name, and date of birth;
- performed additional data matches using other enrollee identifying information (fuzzy matching), as necessary;[28]
- created a sampling frame consisting of 409,862 capitation payments totaling $408,465,511 ($263,335,398 Federal share) that Medicaid agencies made to MCOs on

[28] A fuzzy match is a technique used in computing and data processing to find matches that are not exact but are still close enough to be considered relevant.

behalf of enrollees whose DOD preceded the service period covered by the monthly capitation payment;

- selected for review a stratified random sample of 100 capitation payments made on behalf of enrollees identified as deceased totaling $257,547 ($167,357 Federal share);

- obtained documentation from the Medicaid agency for each sample capitation payment to determine the following:

    - whether the enrollee's first and last name, SSN, and date of birth were correct;

    - whether the MMIS or similar Medicaid agency system identified the enrollee's DOD;

    - whether a capitation payment occurred for the service month;

    - whether any adjustments or recoveries were made for the capitation payment; and

    - the reason a capitation payment was made on behalf of a deceased enrollee, if applicable;

- determined the Federal share of the unallowable payments made after an enrollee's death for each of the sample capitation payments by taking the following steps:

    - obtaining the annual FMAP rates from the Federal Register,

    - adding the 6.2-percent FMAP increase provided through the Families First Coronavirus Response Act, and

    - calculating the Federal payment by multiplying the payment by the applicable FMAP rate;

- used various sources such as Medicaid agency death records, the U.S. Department of the Treasury's DNP system, Accurint, and obituaries to verify the accuracy of the DMF;

- estimated the value of unallowable payments made after an enrollee's death in the sampling frame by using Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software; 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 objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Colorado Made Capitation Payments to Managed Care Organizations After Enrollees' Deaths	A-07-21-05132	02/14/2025
Delaware Made Capitation Payments to Medicaid Managed Care Organizations After Enrollees' Deaths	A-03-22-00205	03/25/2024
Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths	A-04-21-09005	11/24/2023
Puerto Rico Claimed Over $7 Million in Federal Reimbursement for Medicaid Capitation Payments Made on Behalf of Enrollees Who Were or May Have Been Deceased	A-02-21-01005	09/11/2023
Virginia Made Capitation Payments to Medicaid Managed Care Organizations After Enrollees' Deaths	A-03-22-00203	07/19/2023
Kansas Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths	A-07-20-05125	09/01/2021
North Carolina Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths	A-04-16-00112	09/25/2020
The New York State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths	A-04-19-06223	07/27/2020
Michigan Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths	A-05-17-00048	02/14/2020
The Indiana State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths	A-05-19-00007	01/29/2020
The Minnesota State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths	A-05-17-00049	10/01/2019
Illinois Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-05-18-00026	08/20/2019
Georgia Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-04-15-06183	08/09/2019
California Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-04-18-06220	05/07/2019
Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-05-17-00008	10/04/2018

Report Title	Report Number	Date Issued
Wisconsin Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths	A-05-17-00006	09/27/2018
Tennessee Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death	A-04-15-06190	12/22/2017
Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death	A-06-16-05004	11/14/2017
Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death	A-04-15-06182	11/30/2016

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 409,862 net Medicaid capitation payments of $50 or more totaling $408,465,511 that were made during our audit period to MCOs in 35 States, Puerto Rico, and Washington, DC, on behalf of deceased enrollees (see footnote 14).

SAMPLE UNIT

The sample unit was a net capitation payment.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as follows:

Table 1: Strata Based on Net Medicaid Capitation Payments

Stratum	Frame Information			
	Net Capitation Payment Range	**Frame Count**	**Frame Dollar Value**	**Sample Size**
1	$50.24 through $943.07	289,141	$142,402,336	34
2	$943.08 through $2,979.32	99,798	$150,476,117	33
3	$2,979.33 through $47,979.40	20,923	$115,587,057	33
	Totals	**409,862**	**$408,465,511***	**100**
*The difference in the sum is due to rounding.				

SOURCE OF RANDOM NUMBERS

The source of the random numbers was OIG/OAS statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We sorted the items in each stratum by SSN and service month and then consecutively numbered the items in each stratum in the sampling frame. We generated the random numbers for our sample according to our sample design, and we then selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the total dollar value and Federal share of unallowable net capitation payments in our sampling frame made to MCOs and claimed for Federal reimbursement on behalf of enrollees whose dates of death preceded the monthly service periods (during the audit period) covered by the capitation payments.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Number of Net Capitation Payments in Frame	Total Value of Net Capitation Payments in Frame	Sample Size	Total Value of Net Capitation Payments in Sample	Number of Unallowable Net Capitation Payments in Sample	Total Value of Unallowable Net Capitation Payments in Sample	Federal Share of Unallowable Net Capitation Payments in Sample
1	289,141	$142,402,336	34	$17,864	21	$10,759	$7,266
2	99,798	150,476,117	33	50,880	22	31,747	21,383
3	20,923	115,587,057	33	188,804	6	31,532	19,224
Totals	409,862	$408,465,511	100	$257,547	49	$74,039	$47,873
*The differences in the sums are due to rounding.							

Table 3: Estimated Value of Unallowable Net Capitation Payments in the Sampling Frame (Limits Calculated at the 90-percent Confidence Level)

	Total Amount	Federal Share
Point Estimate	$207,501,380	$138,645,710
Lower Limit	$170,890,166	$113,597,808
Upper Limit	$244,112,594	$163,693,612

APPENDIX E: FEDERAL REQUIREMENTS

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 a Medicaid managed care provider is 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, every 5 years, a comprehensive plan for ensuring the integrity of the Medicaid program by combating fraud, waste, and abuse.

APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: November 13, 2025

TO: Megan Tinker
Chief of Staff
Office of Inspector General

FROM: Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General Draft Report: Medicaid Agencies Made Millions in Unallowable Capitation Payments to Managed Care Organizations on Behalf of Deceased Enrollees (A-04-23-09010)

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 is committed to partnering with states to ensure the fiscal integrity of Medicaid and the Children's Health Insurance Program (CHIP). Because Medicaid and CHIP are jointly funded by states and the federal government, and are administered by states within federal guidelines, both CMS and states have key roles as stewards of these programs and work closely together to carry out these responsibilities.

States have some flexibility to determine the services and populations that are covered under the Medicaid state plan and are responsible for accurately determining eligibility for all individuals applying for, or receiving, benefits. CMS provides states with guidance and technical assistance to support them in complying with the applicable federal eligibility-related requirements at 42 CFR Part 435. For example, CMS provides technical assistance to states through 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. In addition, CMS regulations at 42 CFR 438.3(c)(2) clarify that capitation payments may only be made by the state and retained by managed care plans[1] for Medicaid-eligible enrollees. Capitation rates must be actuarially sound and are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract.[2] CMS requires that states include all applicable federal requirements in their managed care plan contracts, including those described in 438.3(c)(2) and 438.608(a)(3)[3]. In an effort to provide transparency on the criteria used for contract approvals and to help states verify that their contracts with Medicaid managed care plans meet all CMS requirements, CMS has provided states with a detailed guide outlining the contract review and approval process.[4]

[1] In this document, "managed care plans" refers to managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans.
[2] 42 CFR § 438.4(a)
[3] 42 CFR § 438.608(a)(3) requires managed care plans to provide prompt notification to the state when the managed care plan receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility, including the death of an enrollee.

[4] 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

However, recent internal and external audits have shown that states have faced challenges with identifying and preventing payments from being made on behalf of individuals who are deceased. In 2022, CMS began piloting a new audit strategy by conducting reviews of three separate managed care plans in West Virginia. Through this audit, CMS identified a total of $1.1 million in capitation payments on behalf of individuals who were deceased. CMS, with support from the Unified Program Integrity Contractors (UPICs), then expanded this audit work to five additional states in 2023 and 20 additional states in 2024. These audits examined several different aspects of managed care plan oversight and performance, including capitation payments made to managed care plans on behalf of individuals who were deceased. To reduce further risk of overpayments and as OIG has noted, CMS issued guidance to states in April 2024 reminding them of the data sources available to match enrollment and payment data against data on deceased individuals.[5] These data sources include the Social Security Administration's (SSA) Death Master File (DMF), State Verification and Exchange System (SVES), State Online Query (SOLQ), Beneficiary and Earnings Data Exchange (BENDEX), and State Data Exchange (SDX). CMS reminded states that they can also access information regarding enrollees who may be deceased from their state department of health and office of vital statistics.

Public Law 119-21 was signed into law on July 4, 2025, and, beginning January 1, 2027, states will be required to check SSA's DMF on at least a quarterly basis to identify any Medicaid enrollees who are deceased. CMS is committed to working with states as they prepare to implement this new requirement.

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

OIG Recommendation 1

Provide the Medicaid agencies covered by our audit with our matched T-MSIS data so that the Medicaid agencies can review the capitation payments and take appropriate action to recover any unallowable payments made on behalf of enrollees whose date of death preceded the monthly service period and not already recovered during their normal review process, which could result in the Medicaid agencies recovering unallowable payments made during our audit period.

CMS Response

CMS concurs with this recommendation. CMS will share the OIG's matched T-MSIS data with the states included in this report and encourage them to review and take appropriate action, including recovering any unallowable payments.

OIG Recommendation 2

Explore opportunities to work with Medicaid agencies to ensure that the related provisions of the OBBB Act are properly implemented. This effort could result in annual estimated savings of $207,501,380 ($138,645,710 Federal share).

CMS Response

As noted above, Public Law 119-21 includes a provision that, effective January 1, 2027, requires states to check SSA's DMF on at least a quarterly basis to identify any Medicaid enrollees who are deceased. CMS is committed to working with states as they prepare to implement this new requirement. CMS requests that the OIG close this recommendation as implemented as CMS already plans to engage with states to ensure implementation of the new requirement.

[5] CMS, Identifying Deceased Medicaid Enrollees. April 25, 2024. Accessed at: https://www.medicaid.gov/federal-policy-guidance/downloads/guidance-04252024.pdf

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