Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Georgia Focused Program Integrity Review

Medicaid Managed Care Oversight

July 2025

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services (CMS) conducted a focused program integrity review to assess Georgia's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid-managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the SMA.

This report includes CMS' findings and resulting recommendations, as well as observations that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified ten findings that create risk to the Georgia Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified **six** recommendations that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. These recommendations include the following:

MCO Contract Compliance

Recommendation #1: To come into compliance with § 438.608(a)(5), Georgia should amend the MCO general contract to contain language regarding a method to verify whether services that have been represented to have been delivered by network providers were received by enrollees.

Recommendation #2: In accordance with § 438.608(a)(6), Georgia should amend the MCO general contract to contain language requiring the development and maintenance of written policies for all employees and agents. This contract language should provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. Additionally, Georgia should establish a documented process of how it verifies MCOs have written policies to comply with§ 438.608(a)(6).

Recommendation #3: To come into compliance with § 438.608(a)(8), Georgia should include language in the MCO general contract requiring MCOs to develop policies and procedures requiring the suspension of payments to a network provider for which DCH or MFCU determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23.

Recommendation #4: In accordance with § 438.608(d)(3), Georgia should develop written policies and procedures for ensuring MCOs annually report recoveries of overpayments to the state. In addition, the state should ensure the MCO general contract requires MCOs to promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. Additionally, in accordance with § 438.608(a)(2), the state should develop a process to ensure MCOs have an internal overpayment tracking systems to better account for and report overpayment information.

Recommendation #5: In accordance with § 438.608(d)(2), Georgia should amend the general contract to include language requiring MCOs to establish a mechanism for network providers to report and return identified overpayments to the MCO within 60 calendar days as well as to notify the MCO in writing of the reason for the overpayments.

MCO Investigations of Fraud, Waste, and Abuse

Recommendation #6: In accordance with §§ 438.608(a)(7) and 455.13-17, Georgia should include language in the MCO general contract on prompt referral of potential fraud, waste, and abuse that the MCO identifies to the state.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **four** observations related to Georgia's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: Based on the quantity and quality of cases investigated and referred during the review period, CMS encourages Georgia to include a Special Investigation Unit (SIU) staffing ratio requirement in the MCO general contract.

MCO Contract Compliance

Observation #2: CMS encourages Georgia to develop formal policies and procedures for the annual review of MCO compliance plans and fraud, waste, and abuse plans. CMS further encourages Georgia to develop an effective monitoring tool for the annual submission,

review, and approval of MCO compliance plans. Such a tool may include a template or checklist outlining the required compliance plan requirements under CMS regulations and the Georgia MCO general contract.

MCO Investigations of Fraud, Waste, and Abuse

Observation #3: CMS encourages Georgia to work with the MCOs to develop more case referrals and routinely provide specific program integrity training aimed at enhancing the identification and quality of case referrals from the MCOs. CMS also encourages Georgia to provide more frequent feedback to the MCOs regarding the quality of case referrals.

Observation #4: CMS encourages Georgia to urge MCOs to resume conducting announced and unannounced investigative provider site visits to oversee network providers more effectively now that the public health emergency has ended.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between SMAs and MCOs that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Georgia Managed Care Program and the Focused Program Integrity Review

The Georgia Department of Community Health (DCH) is responsible for the administration of the Georgia Medicaid program, Medical Assistance Plan. Managed care is provided through the Georgia Families or Georgia Families 360° programs. Within DCH, the Office of Inspector General Program Integrity Unit (PIU) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Georgia contracted with four Care Management Organizations to provide health services to the Medicaid population. For purposes of this report, Care Management Organizations will be referred to as MCOs. As part of this review, three of these MCOs were interviewed: Amerigroup, CareSource, and Peach State Health Plan (Peach State). Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In July 2023, CMS conducted a virtual focused program integrity review of Georgia's managed

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

care program. This review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the SMA. CMS interviewed key staff, including the MCOs' SIUs, and reviewed other primary data. CMS also evaluated the status of Georgia's previous corrective action plan that was developed in response to a previous focused program integrity review of Georgia's managed care program conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified a total of **six** recommendations and **four** observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.

C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and

completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

In Georgia, these oversight and monitoring requirements are met. Monitoring of the MCOs' performance is a collaborative effort between DCH's compliance and performance and care management units, as well as DCH contractors, such as Myers and Stauffer to perform onsite procedures to monitor MCOs for contract compliance, encounter submissions, program integrity oversight, and subcontractor oversight. On a rotating basis, Myers and Stauffer conducts MCO reviews through interviews, onsite claims review, and pharmacy benefit manager (PBM) reviews. The reviews by Myers and Stauffer consist of obtaining policies and procedures related to contract compliance in the areas of the compliance plan, program integrity oversight, encounter submissions, subcontractor oversight, utilization management, behavioral health, provider network, claims management, and third-party liability. The results of these reviews are posted to the DCH website. The DCH also contracts with Alliant to validate compliance with applicable health care policies, determine instances of incorrect billing, and/or medically unnecessary or inappropriate services for waiver programs. These audit activities consist of comprehensive, prepayment, peer network, member surveillance, and post-payment utilization reviews. Both vendors submit annual, monthly, and quarterly reports. The PIU conducts monthly meetings with all contracted vendors.

Georgia's MCOs are required to ensure the appropriate utilization of resources through mechanisms such as prior authorization, concurrent reviews, prospective reviews, case management, and discharge planning. Each MCO must have a PBM, and claims processing system that allows for the submission, processing, editing, and adjudication of claims.

During the review, CMS noted that the PIU only investigates fee-for-service providers, not MCO providers. Investigating MCO providers has been delegated to the MCOs. The PIU approves MCO requests for investigation of managed care providers and monitors oversight of investigations, overpayments, as well as fraud referrals sent to the PIU for the MFCU. While not a CMS requirement, SIU staffing ratios are not defined in the MCO general contract, and the PIU has not completed a staffing ratio analysis. CMS believes conducting such activities are an effective way to ensure adequate oversight structures of managed care programs.

Observation #1: Based on the quantity and quality of cases investigated and referred during the review period, CMS encourages Georgia to include a SIU staffing ratio requirement in the MCO general contract.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for Georgia is developed by the DCH Managed Care Compliance Unit (MCCU). The DCH MCCU works in collaboration with other units within DCH including Performance and Care Management, Program Integrity, Pharmacy, and Finance. On June 30, 2022, DCH submitted an updated MCO contract to CMS for approval with several changes to Section 4.13 Fraud, Waste, and Abuse. The changes to the contract language were in response to recommendations identified in the 2018 Managed Care Focused Program Integrity Review conducted by CMS and the 2020 performance audit conducted by the Georgia Department of Audits & Accounts.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract.
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.
5. Effective lines of communication between the Compliance Officer and employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as

> identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Section 4.13.2 of Georgia's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans and programs found that each MCO's compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii). However, DCH does not perform, or have a documented process for, an annual review of the compliance plans submitted to DCH by the MCOs, and CMS noted that the MCOs do not submit their compliance plans on regular basis.

> **Observation #2**: CMS encourages Georgia to develop formal policies and procedures for the annual review of MCO compliance plans and fraud, waste, and abuse plans. CMS further encourages Georgia to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans. Such a tool may include a template or checklist outlining the required compliance plan requirements under CMS regulations and the Georgia MCO general contract.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Georgia, this requirement is not met because the MCO general contract does not contain language regarding beneficiary verification of services. Although not required by the MCO general contract, the MCOs have been utilizing a variety of methods to conduct beneficiary verification of services including mailing of service verifications and outreach phone calls.

> **Recommendation #1:** To come into compliance with § 438.608(a)(5), Georgia should amend the MCO general contract to contain language on a method to verify whether services that have been represented to have been delivered by network providers were received by enrollees.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The state is not compliant with this requirement. The MCO general contract did not

contain the required False Claims Act language during the review period.

> **Recommendation #2:**
> In accordance with § 438.608(a)(6), Georgia should amend the MCO general contract to contain language requiring the development and maintenance of written policies for all employees and agents. This contract language should provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. Georgia should establish a documented process of how it verifies MCOs have written policies to comply with § 438.608(a)(6).

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Georgia Medicaid MCOs are not contractually required to suspend payments to providers at the state's request for providers for which the state determines there is a credible allegation of fraud. While this requirement is not addressed in the MCO general contract, DCH has developed a business process for the handling of payment suspensions for fee-for-service providers that are also MCO providers. The DCH PIU forwards all requests for suspension to the MCO through an email drop box. The MCOs provide feedback and notify DCH PIU when the provider has been suspended.

> **Recommendation #3:** To come into compliance with § 438.608(a)(8), Georgia should include language in the MCO general contract requiring MCOs to develop policies and procedures requiring the suspension of payments to a network provider for which DCH or MFCU determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the

information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

The state did not adequately address the requirements at §§ 438.608(a)(2) and (d). CMS found that the MCO contracts for the review period did not include language requiring MCOs to have a process for network providers to report and return excess capitation or overpayments to the MCO within 60 calendar days, as required in § 438.608(d)(2). In addition, the executed contracts between the MCOs and the state did not include provisions for MCOs to report recoveries of overpayments annually as required by § 438.608(d)(3). CMS noted that DCH does not have policies and procedures in place to verify overpayment recovery information is received from the MCOs or have provisions in place for the prompt reporting of all overpayments identified or recovered, specifying which overpayments were due to potential fraud, as required in § 438.608(a)(2). The DCH reported that only Amerigroup had identified and returned overpayments, including overpayments due to fraud and abuse, to the state during the review period.

Overall, the number of overpayments identified and recovered as reported by the MCOs is low for a managed care program of Georgia's size. Detailed information regarding overpayments identified and recovered by the MCO can be found in Table 1, section D, of this report.

> **Recommendation #4:** In accordance with § 438.608(d)(3), Georgia should develop written policies and procedures for ensuring MCOs annually report recoveries of overpayments to the state. In addition, the state should ensure the MCO general contract requires MCOs to promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. Additionally, in accordance with § 438.608(a)(2), the state should develop a process to ensure MCOs have an internal overpayment tracking system to better account for and report overpayment information.
>
> **Recommendation #5**:
> In accordance with § 438.608(d)(2), Georgia should amend the general contract to include language requiring MCOs to establish a mechanism for network providers to report and return identified overpayments to the MCO within 60 calendar days as well as to notify the MCO in writing of the reason for the overpayments.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of

suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. Georgia has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by 455.21(c)(3)(iv). Additionally, the state meets with the MFCU quarterly to discuss case referrals.

In accordance with the MOU, the MCOs send fraud referrals to the PIU for internal vetting. The PIU evaluates MCO fraud referrals on a case-by-case basis to determine if credible allegations of fraud exist to warrant referral to MFCU. If the PIU determines credible allegations of fraud exist, the referral is uploaded to SharePoint and sent to MFCU. The SharePoint site is used to track the status of fraud referrals and correspondence received from DCH PIU. Within 30 days of receiving a MCO fraud referral from DCH, MFCU will determine whether to send the referral back to DCH for MCO administrative action or to accept the referral and open a full investigation. When the MFCU receives a referral from DCH, the referral will be acknowledged in writing within 3business days. The PIU sends MCO and fee-for-service claims data to the MFCU to identify total exposure. This enables the MFCU to accept or reject an MCO fraud referral within 30 days. The MFCU notifies the PIU in writing with a request not to suspend payments, when necessary, to avoid compromising a law enforcement investigation. If the referral is accepted, MFCU will open a preliminary investigation. If rejected, the MFCU will return the referral to the PIU which is forwarded to the MCO for administrative resolution. The MFCU sends reports of conviction and sentencing documents to the PIU and Provider Enrollment section. The MFCU has expressed concerns with the quality of MCO referrals.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold monthly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions.

CMS did not identify any findings or observations related to these requirements.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Georgia has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). Georgia developed and implemented business processes for MCO fraud referrals and investigations and

updated the MOU with the MFCU in March 2021. **However, these processes were not included in the MCO contracts during the review period.** These business processes should include prompt referral of investigations to the PIU to determine if a credible allegation of fraud exists. If the PIU decides a credible allegation of fraud exists, the PIU subsequently refers the investigation to the MFCU. Under this business process, timelines and standards for fraud referrals requires that within 143 days of issuing a case number the MCOs must send a fraud referral to the PIU for evaluation to determine if credible allegations of fraud exist for referral to the MFCU. Additionally, within 155 days of the issuance of a case number, the MCOs must send a request for approval to pursue an overpayment.

During the review, Georgia acknowledged the lack in quality and quantity of fraud referrals. In an effort to improve fraud referrals the PIU has been working with the MCOs and the MFCU. During the Public Health Emergency, the PIU established a MFCU SharePoint site to track managed care fraud referrals which allows for the PIU to track updates regarding the status of the managed care fraud referrals.

> **Recommendation #6:** In accordance with §§ 438.608(a)(7) and 455.13-17, Georgia should include language in the MCO general contract on prompt referral of potential fraud, waste, and abuse that the MCO identifies to the state.

> **Observation #3:** CMS encourages Georgia to work with the MCOs to develop more case referrals and routinely provide specific program integrity training aimed at enhancing the identification and quality of case referrals from the MCOs. CMS also encourages Georgia to provide more frequent feedback to the MCOs regarding the quality of case referrals.

MCO Oversight of Network Providers

CMS verified whether each Georgia MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

All three MCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified by the MCOs through different sources, including but not limited to data analytics that are exploratory, confirmatory, and predictive, data mining tools and algorithms, anomaly detection, referrals, and hotline calls. A preliminary investigation is completed by the MCO to see if the case should be opened by the SIU. When a case is opened as a result of the preliminary investigation, a referral is sent to the state and a full investigation is conducted.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state MCO contract requirements at Section 4.13. However, it was noted that the MCOs were conducting a limited number of announced or unannounced provider site visits during the public health emergency, which fell within the review period. Amerigroup conducted one announced site visit during 2020 and 2021, and one

unannounced site visit during 2020. CareSource conducted two unannounced site visits in 2022, whereas Peach State did not conduct any site visits during the review period.

Figure 1 below describes the number of investigations referred to Georgia by each MCO. As illustrated, the number of Medicaid MCO provider referrals is low.

Figure 1. Number of Investigations Referred to Georgia by each MCO

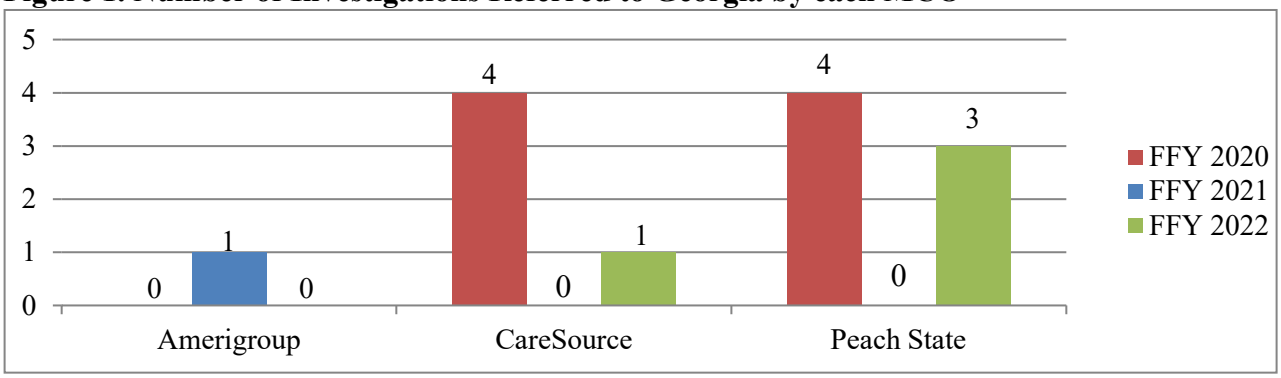

Table 1-A, 1-B, and 1-C below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

Table 1-A: Amerigroup's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	66	80	$617,259.00	$96,891.69
2021	91	61	$176,013.22	$41,992.97
2022	140	87	$401,343.35	$89,866.11

Table 1-B: CareSource's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	227	52*	$130,647.64	$219,099.00
2021	265	17	$109,701.18	$46,261.00
2022	316	14	$66,255.77	$3,900.00

* - Of the cases reported in FFY2020, 38 cases were opened prior to the review period, but were active cases during the review period.

Table 1-C: Peach State's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	59	18	$835,628.84	$191,704.04
2021	22	25	$16,381.68	$134,630.73
2022	54	65	$384,421.26	$124,234.54

Observation #4: CMS encourages Georgia to urge MCOs to resume conducting announced and unannounced investigative provider site visits to oversee network providers more effectively now that the public health emergency has ended.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the Georgia MCO general contract and interviews with each of the MCOs, CMS determined that Georgia was in compliance with § 438.242. Specifically, the contract language in Section 4.16 includes all the necessary provisions in accordance with § 438.242. The MCOs are contractually required to submit encounter data to DCH, no less frequently than weekly in the required claim format. CMS determined during the review that the MCOs were in compliance with this requirement. The state provides response files to the MCOs' weekly submissions that provides an accepted or rejected status, and the details of any rejected encounters. These encounters are used for evaluation of the appropriateness for capitation rate setting, budgeting, following public health trends, and detecting potential fraud. The state receives the following reports in order to audit the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the managed care plans: Annual Medical Loss Ratio Report and Weekly Encounter Data Reports.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. Georgia was in compliance with § 438.602(e). Specifically, Myers and Stauffer, DCH's contracted Recovery Audit Contractor, performs a full audit every three years of the MCOs, with the results of each being published to DCH's website.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by

MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Georgia has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, DCH utilizes a collection of oversight reports, summarization and trending analyses, and outside vendors to review MCO encounter data. The DCH also utilizes a wide variety of algorithms to identify aberrant billing trends on a quarterly basis.

IV. Conclusion

CMS supports Georgia's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified six recommendations and four observations that require the state's attention.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendations have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Georgia to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

Georgia's last CMS program integrity review was in April 2018, and the report for that review was issued in November 2018. The report contained ten recommendations. During the virtual review in July 2023, the CMS review team conducted a thorough review of the corrective actions taken by Georgia to address all recommendations reported in calendar year 2018. The findings from the 2018 Georgia focused PI review report have not all been satisfied by the state.

Findings

1. ***Refine the fraud, waste, and abuse section of the general MCO contract incorporating the key elements of the program integrity operations, as well as the requirements expected to be performed in order to meet all program integrity federal regulations for the Medicaid managed care program. The fraud, waste, and abuse section of the contract should lay out more specific program integrity requirements in order to avoid misunderstandings due to generalities and ambiguity.***
   Status at time of the review: Not Corrected

   Georgia will amend its MCO contract to incorporate the required elements. Training will be provided to the Department's staff and the MCO's staff to ensure that staff are familiar with the new provisions. Additionally, monitoring and oversight will be completed to ensure compliance.

2. ***Develop a monitoring tool that is linked to the fraud, waste, and abuse section of the contract and its requirements. At a minimum, implement an annual review of each MCO in order to assess compliance with meeting all contract program integrity requirements.***
   Status at time of the review: Corrected

3. ***Develop, compile, implement, and update as necessary, written policies and procedures addressing all program integrity functions. This would also include a referral policy.***
   Status at time of the review: Corrected

4. ***Given the limited number of provider investigations and referrals by the MCOs along with the low number of overpayments and terminations that the MCOs reported, the state should ensure that both the DCH/OIG and its MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud.***
   Status at time of the review: Not Corrected

   Georgia will amend its MCO contract to require that each MCO have a SIU dedicated solely to the Georgia Medicaid/Peach Care for Kids Program. The DCH will conduct quarterly trending and analysis of the volume and status of provider investigations, referrals, overpayments, and terminations conducted by the MCOs. Additionally, annual

training will be provided to DCH's staff and the MCO's staff to ensure compliance.

5. ***The DCH/OIG should obtain feedback from the MFCU regarding the quantity and quality of MCO referrals reviewed and develop a strategy for improving MCO referrals.***
   Status at time of the review: Not Corrected

   Georgia will meet with the MFCU on a monthly basis to obtain the required feedback and to identify and develop strategies to improve MCO referrals.

6. ***The DCH/OIG, in conjunction with the MFCU when possible, should work with the MCOs to develop and provide program integrity training on a routine basis to enhance case referrals from the MCOs. The state should ensure that MCO staff, primarily the SIU and/or Compliance Officer, is receiving adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.***
   Status at time of the review: Not Corrected

   Georgia will implement mandatory bi-annual trainings. Written policies and procedures will be developed and reviewed during the training sessions.

7. ***The DCH/OIG should implement proactive audits of validated managed care claims encounter data.***
   Status at time of the review: Corrected

8. ***Review the regulations at 42 CFR 455.23 completely and refine current payment suspension policies and procedures to ensure that DCH/OIG determines whether an allegation of fraud is credible. As soon as DCH/OIG determines there is a credible allegation of fraud, it should refer the case to the MFCU and suspend payment unless there is a basis to exercise good cause not to suspend. In determining whether there is good cause, DCH/OIG must consider each case referred to the MFCU on its own merits and not routinely exercise good cause in every case. This will help the state agency to identify where it can safely suspend Medicaid payments to potentially fraudulent providers without jeopardizing further investigation of those providers.***
   Status at time of the review: Corrected

9. ***Amend the general MCO contract language to ensure the appropriate actions are taken by MCOs to suspend, exclude or terminate providers from its Medicaid program in coordination with DCH/OIG when there is cause to do so.***
   Status at time of the review: Not Corrected

   Georgia will revise the MCO contract to include these requirements.

10. ***Review and address any state laws that conflict with the regulation at 455.23 regarding payment suspensions. Consequently, assess whether the state's MOU with the MFCU should be revised to incorporate any necessary improved case referral and payment***

suspension procedures that complies with the regulation at 42 CFR 455.23. Conduct relevant training to all contracted entities that refer directly to the MFCU on any new procedures, as required.

Status at time of the review: Corrected

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for Georgia MCOs

(Select State)(Select State) MCO Data	Amerigroup	CareSource	Peach State
Beneficiary enrollment total	582,175	423,400	1,009,191
Provider enrollment total	31,441	30,277	38,658
Year originally contracted	2006	2017	2006
Size and composition of SIU	14*	33**	7***
National/local plan	National	National	National/Local

* - Of the fourteen, seven are dedicated to Georgia SIU functions, with seven support staff. Amerigroup is a subsidiary of Amerigroup Corporation, a wholly owned subsidiary of Anthem, Inc., and is supported by Amerigroup Corporation's SIU.
** - Of the thirty-three corporate SIU staff, three are dedicated to and located in Georgia.
*** - All seven are dedicated to Georgia. Peach State is a subsidiary of Centene Corporation and is supported by the corporate SIU.

Table C-2. Medicaid Expenditure Data for Georgia MCOs

MCOs	FY 2020	FY 2021	FY 2022
Amerigroup	$1,289,979,126	$1,562,552,653	$1,851,767,626
CareSource	$785,470,141	$1,040,502,450	$1,349,701,806
Peach State	$1,100,887,909	$1,882,623,320	$2,943,689,415
Total MCO Expenditures	$3,176,337,176.00	$4,485,678,423.00	$6,145,158,847.00

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	To come into compliance with § 438.608(a)(5), Georgia should include language in its MCO general contract regarding the development of a method to verify whether the represented services have been received by the beneficiaries.	**X**	
Recommendation #2	In accordance with § 438.608(a)(6), Georgia should amend the MCO general contract to contain language requiring the development and maintenance of written policies for all employees and agents. This contract language should provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. Additionally, Georgia should establish a documented process demonstrating how it validates MCOs having written policies that provide the detailed information listed above.	**X**	
Recommendation #3	To come into compliance with § 438.608(a)(8), Georgia should include language in the MCO general contract requiring MCOs to develop policies and procedures requiring the suspension of payments to a network provider for which DCH or MFCU determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23.	**X**	
Recommendation #4	In accordance with § 438.608(d)(3), Georgia should develop written policies and procedures for ensuring MCOs annually report recoveries of overpayments	**X**	

Classification	Issue Description	Agree	Disagree
	to the state. In addition, the state should ensure the MCO general contract requires MCOs to promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. Additionally, in accordance with § 438.608(a)(2), the state should develop a process to ensure MCOs have an internal overpayment tracking systems to better account for and report overpayment information.		
Recommendation #5	In accordance with § 438.608(d)(2), Georgia should amend the general contract to include language requiring MCOs to establish a mechanism for network providers to report and return identified overpayments to the MCO within 60 calendar days as well as to notify the MCO in writing of the reason for the overpayments.	**X**	
Recommendation #6	In accordance with §§ 438.608(a)(7) and 455.13-17, Georgia should include language in the MCO general contract on prompt referral of potential fraud, waste, and abuse that the MCO identifies to the state.	**X**	

Acknowledged by:**)**

Sonja Allen-Smith

[Name], [Title]

August 14, 2025

Date (MM/DD/YYYY)