



May 5, 2010

**TO:** Marilyn Tavenner  
Acting Administrator and Chief Operating Officer  
Centers for Medicare & Medicaid Services

**FROM:** Daniel R. Levinson  
Inspector General

**SUBJECT:** Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program (A-06-08-00078)

The attached final report provides the results of our oversight and evaluation of the fiscal year (FY) 2007 Payment Error Rate Measurement (PERM) program. The Centers for Medicare & Medicaid Services (CMS) developed the PERM program to comply with the Improper Payments Information Act of 2002, P.L. No. 107-300, and Office of Management and Budget requirements for measuring improper Medicaid program and State Children's Health Insurance Program (SCHIP, now known as CHIP) payments. CMS's PERM program measures improper payments made in the fee-for-service, managed care, and eligibility components of Medicaid and SCHIP in FY 2007 and future years.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph J. Green, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through email at [Joe.Green@oig.hhs.gov](mailto:Joe.Green@oig.hhs.gov). Please refer to report number A-06-08-00078 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**OVERSIGHT AND EVALUATION OF THE  
FISCAL YEAR 2007 PAYMENT ERROR  
RATE MEASUREMENT PROGRAM**



Daniel R. Levinson  
Inspector General

May 2010  
A-06-08-00078

# *Office of Inspector General*

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

The Improper Payments Information Act of 2002 (IPIA) requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. In addition, for any program or activity with estimated improper payments exceeding \$10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments. Section 2(f) of the IPIA requires the Director of the Office of Management and Budget (OMB) to prescribe guidance on implementing IPIA requirements.

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and OMB requirements for measuring improper Medicaid program and State Children's Health Insurance Program (SCHIP, now known as CHIP) payments. CMS's PERM program measures improper payments made in the fee-for-service (FFS), managed care, and eligibility components of Medicaid and SCHIP in fiscal year (FY) 2007 and future years.

Three contractors were responsible for operating the FY 2007 PERM program: a statistical contractor, a documentation/database contractor, and a review contractor.

### **OBJECTIVE**

Our objective was to determine whether the PERM program produced a reasonable estimate of improper FY 2007 FFS and managed care payments for both Medicaid and SCHIP.

### **SUMMARY OF FINDINGS**

We were unable to determine whether the PERM program produced a reasonable estimate of improper FY 2007 FFS and managed care payments for both Medicaid and SCHIP for the following reasons:

- The statistical contractor sampled payments from State universes that were or may have been incomplete or inaccurate.
- The estimate of improper payments for SCHIP did not meet the required precision levels.
- CMS did not review States' repricing of the payment amounts for claims found to be partially in error.

## **RECOMMENDATIONS**

We recommend that CMS:

- continue to work with the States, CMS Regional Offices, and the statistical contractor on reconciling the PERM universes to State financial reports;
- work with OMB to establish new precision-level requirements for PERM;
- request the States to verify the accuracy of all repriced claims and submit documentation supporting the repricing; and
- test repriced claims for accuracy.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its comments on our draft report, CMS agreed with our recommendations and proposed corrective actions. CMS's comments are included in their entirety as Appendix E.

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# INTRODUCTION

## BACKGROUND

### **Improper Payments Information Act of 2002**

The Improper Payments Information Act of 2002 (IPIA), P.L. No. 107-300, requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. In addition, for any program activity with estimated improper payments exceeding \$10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments. Pursuant to section 2(f) of the IPIA, the Director of the Office of Management and Budget (OMB) must prescribe guidance on implementing IPIA requirements.

### **Improper Payments Information Act of 2002 Implementation Guidance**

Unless a written waiver is obtained from OMB, OMB Circular A-123, Appendix C, requires an agency to:

Review all programs and activities and identify those which are susceptible to significant erroneous payments. ... Obtain a statistically valid estimate of the annual amount of improper payments in programs and activities. ... Implement a plan to reduce the erroneous payments. ... [and] Report estimates of the annual amount of improper payments in programs and activities and progress in reducing them.

In its *Implementation Guidance*, OMB identified the Medicaid program and the State Children's Health Insurance Program (SCHIP)<sup>1</sup> as programs at risk for significant erroneous payments. OMB requires the Department of Health & Human Services (HHS) to report the estimated amount of improper payments for each program annually in its accountability report. For example, the fiscal year (FY) 2007 Medicaid and SCHIP improper payments totaled \$18.6 billion and \$0.8 billion (Federal share), respectively, and were reported in the HHS *FY 2008 Agency Financial Report*, dated November 17, 2008.

### **Payment Error Rate Measurement Program**

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and OMB requirements for measuring improper Medicaid and SCHIP payments.<sup>2</sup> CMS's current PERM program measures improper

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<sup>1</sup> On February 4, 2009, this program was renamed the Children's Health Insurance Program. Because our findings relate to FY 2007, we use the SCHIP name throughout the report.

<sup>2</sup> CMS issued the following rules to implement its PERM program: proposed rule, 69 Fed. Reg. 52620 (Aug. 27, 2004); interim final rule with comment period, 70 Fed. Reg. 58260 (Oct. 5, 2005); second interim final rule with comment period, 71 Fed. Reg. 51050 (Aug. 28, 2006); and final rule, 72 Fed. Reg. 50490 (Aug. 31, 2007) (as codified at 42 CFR §§ 431.950–431.1002).

payments made in the fee-for-service (FFS), managed care, and eligibility components of Medicaid and SCHIP in FY 2007 and future years.

### **Payment Error Rate Measurement Program Process**

For PERM, Medicaid and SCHIP are divided into three different components: FFS, managed care, and eligibility. Each component has separate universes, samples, and error estimates. The States are responsible for compiling the Medicaid and SCHIP claims universes on a quarterly basis and the eligibility universes on a monthly basis. CMS requires States to submit quarterly to the statistical contractor one universe each for FFS and managed care. The statistical contractor selects a sample from each of the quarterly universes. The FFS sample size is 500 claims per year per State, and the managed care sample size is 250 claims per year per State. CMS also requires each State to select a sample of Medicaid and SCHIP eligibility case files to determine whether they were correctly approved or denied. The eligibility sample is split between eligible case files (504) and ineligible case files (204).

CMS used three contractors for the FY 2007 PERM program: a statistical contractor, a documentation/database contractor, and a review contractor. The statistical contractor was responsible for selecting 17 sampled States,<sup>3</sup> collecting and stratifying State universe information,<sup>4</sup> selecting quarterly samples of claims<sup>5</sup> for each of the 17 States, calculating the estimated amount of State and national Medicaid and SCHIP improper payments, and writing the final PERM report for CMS. The documentation/database contractor was responsible for receiving the claim information from the States, requesting State Medicaid policies, and requesting medical records from providers. The review contractor was responsible for using the policies and medical records obtained by the documentation/database contractor to perform medical and data processing reviews, resolving differences in State and review contractor determinations, working with States to determine new payment amounts (to reprice) for claims partially in error, providing determinations to the statistical contractor, and assisting the statistical contractor in writing the final PERM report.

### **Waiver on Selection of States**

Pursuant to OMB Circular A-123, Appendix C, an agency is required to develop a statistically valid estimate of erroneous payments unless OMB grants specific written approval (i.e., a waiver). CMS obtained a waiver from OMB allowing CMS to use an alternate sampling methodology that would allow every State to participate in the PERM program only once over a 3-year period, resulting in 17 States participating in the PERM program every year.

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<sup>3</sup> The “States” include all 50 States and the District of Columbia.

<sup>4</sup> In this report, we use the term “State universe” to refer to all of the claim information from which a State’s samples were selected.

<sup>5</sup> The PERM sampling unit is the lowest separately priced unit on a beneficiary-specific claim. This is typically a line item. However, for some types of claims, such as those representing diagnostic-related groups, the lowest separately priced item is the claim itself. We refer to the sampling unit as a “claim” in this report.

## **State Financial Reporting Requirements**

The CMS *State Medicaid Manual*, section 2500, requires that the amounts reported on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) be actual expenditures and be in readily reviewable form. The information for Form CMS-64 expenditures is obtained from invoices, cost reports, eligibility records, and other sources. States should not claim estimated expenditure amounts on the Form CMS-64. CMS guidance on the Quarterly State Children's Health Insurance Program Statement of Expenditures for Title XXI (Form CMS-21) is the same as for Form CMS-64.

In our review of the FY 2006 PERM program, we found that the Medicaid FFS universes from four States for one quarter did not reconcile to the Form CMS-64. In the *PERM FFY 2009 Universe Data Submission Instructions*, CMS is requiring States to compare their quarterly PERM universes to Forms CMS-64 and CMS-21 from the two previous quarters to ensure that all applicable programs from all necessary data sources are included in their PERM universes. CMS is also requiring the statistical contractor to reconcile each State's quarterly universe to that quarter's Forms CMS-64 and CMS-21. If the reconciliation results in a variance of more than 15 percent, the statistical contractor will have to follow up with the State. After universe submissions are complete, the statistical contractor will follow up with the CMS Regional Offices and the States to account for variances between PERM universes and Forms CMS-64 and CMS-21 of more than 5 percent.

## **Precision-Level Requirements**

OMB Circular A-123, Appendix C, states that Federal agencies must produce a statistically valid error estimate that meets precision levels of plus or minus 2.5 percentage points with a 90-percent confidence interval or plus or minus 3 percentage points with a 95-percent confidence interval. In the CMS-issued *Federal Register*, 72 Fed. Reg. 50490, 50495 (Aug. 31, 2007), the national error estimate should meet precision levels of plus or minus 2.5 percentage points with a 90-percent confidence interval, and the State error estimates should meet precision levels of plus or minus 3 percentage points with a 95-percent confidence interval.

## **Repricing Instructions**

The review contractor statement of work requires the review contractor to acquire the fee schedules from the States for claims determined to be in error for less than the full amount or request that each State reprice the errors. If the State fails to provide repricing information, the review contractor is to count the claim as 100 percent in error.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the PERM program produced a reasonable estimate of improper FY 2007 FFS and managed care payments for both Medicaid and SCHIP.

## **Scope**

We reviewed the methodology that the statistical contractor used to select the sampled States and claims and estimate the annual amount of improper payments. We also reviewed the accuracy of four States' universes.

We selected our judgmental sample of 170 claims from all of the claims that the statistical contractor sampled during FY 2007.

We attempted to verify the pricing on all claims that the States were asked to reprice.

We did not review the overall internal control structure of the PERM contractors, the States, or CMS, nor did we independently verify the error rate calculation.

We performed fieldwork at The Lewin Group (the statistical contractor), in Falls Church, Virginia; Livanta, LLC (the documentation/database contractor), in Annapolis Junction, Maryland; and HealthDataInsights, Inc. (the review contractor), in Las Vegas, Nevada. We also visited the California Department of Health Care Services in Sacramento, California; California Managed Risk Medical Insurance Board in Sacramento, California; South Carolina Department of Health and Human Services in Columbia, South Carolina; Rhode Island Department of Human Services in Cranston, Rhode Island; and Bureau of TennCare in Nashville, Tennessee.

## **Methodology**

To accomplish our objectives, we:

- met with CMS officials and PERM contractors to obtain an understanding of the PERM process;
- selected a judgmental sample of 170 claims (10 claims from each of the 17 States the statistical contractor sampled) and traced the sampled claims through the PERM process (statistical sampling, medical record request, medical review, and error estimate calculation);
- performed limited testing and analysis of the PERM sampling and estimation methodology, medical records request process, and medical review process;
- met with officials from four judgmentally selected States to obtain an understanding of the PERM process at the State level;
- attempted to reconcile the four selected States' Forms CMS-64 and CMS-21 to their State universes;

- attempted to verify the pricing on 71 claims that the review contractor asked the States associated with the claims to reprice by obtaining each State’s fee schedules and pricing methodology; and
- reviewed the precision levels of the estimates of improper payments.

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

### **FINDINGS AND RECOMMENDATIONS**

We were unable to determine whether the PERM program produced a reasonable estimate of improper FY 2007 FFS and managed care payments for both Medicaid and SCHIP because:

- The statistical contractor sampled payments from State universes that were or may have been incomplete or inaccurate.
- The estimate of improper payments for SCHIP did not meet the required precision levels.
- CMS did not review the States’ repricing actions.

### **UNIVERSES WERE OR MAY HAVE BEEN INCOMPLETE OR INACCURATE**

The statistical contractor selected samples of paid claims from State paid-claims universes that may not have been complete and accurate. The PERM program did not require the statistical contractor or the States to reconcile the State universes of adjudicated claims to any financial reports. Likewise, the statistical contractor’s quality assurance procedures did not require reconciling the State universes to financial reports. Therefore, CMS had no assurance that the State universes were complete and accurate.

The statistical contractor provided instructions to the States regarding which payments to include in their State universes. According to a CMS-approved letter from the statistical contractor to State health officials providing claims data submission instructions for the FY 2007 PERM program, the PERM universe<sup>6</sup> should have consisted of all adjudicated Medicaid and SCHIP FFS and managed care claims that were originally paid or denied payment from October 1, 2006, through September 30, 2007, and that involved Federal financial participation. If States followed all guidance correctly, the PERM universe should have contained all Medicaid and SCHIP FFS and managed care payments, including those processed outside the States’ payment systems. Each PERM universe should have included claims for which the States had no additional

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<sup>6</sup> For this report, we use the term “PERM universe” to refer to all claim information from all States to be sampled in a specific time period.

payment liability because, for example, a third party was liable or a Medicare or SCHIP payment exceeded the States' allowable charges.

Because we were not able to reconcile the State universes from the four States to their Forms CMS-64 or CMS-21, we could not determine whether all required claims had been included in the State universes. A discussion of the reconciliation of the four States' FFS and managed care universes follows.

## **State One**

### *Managed Care Universes*

State One's managed care system did not maintain beneficiary-specific payment records in its payment system. As a result, State officials created pseudo managed care universes to review the State's managed care payments (for PERM purposes only). Officials created the pseudo universes by:

- accessing monthly copies of the Medicaid and SCHIP eligibility system, archived on the 15<sup>th</sup> of each month;
- identifying the individuals who were in the eligibility system on the 15<sup>th</sup> of that month and enrolled in a health maintenance organization (HMO) and determining what their rate categories were; and
- creating a pseudo payment record for each HMO member-month with the data fields required for the PERM managed care universes.

We were able to reconcile the universes of claims for the first and fourth quarters of the FY 2007 SCHIP managed care stand-alone program to the State's Forms CMS-21 data.<sup>7</sup> However, we were unable to reconcile the State's pseudo Medicaid and SCHIP expansion program managed care claim universes for the first and fourth quarters of FY 2007 to the State's Forms CMS-64 and CMS-21. Although we discussed our attempted reconciliation with State officials and they provided additional information, we still were unable to reconcile the State's Forms CMS-64 and CMS-21 to the PERM universes. The differences we identified during the reconciliation process are shown in Appendix A.

Because we were unable to reconcile the pseudo managed care universes to the Forms CMS-64 and CMS-21 data, we were not able to determine whether the State's pseudo managed care universes were complete and accurate.

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<sup>7</sup> When developing its SCHIP program, each State has the option of making SCHIP part of Medicaid expansion program, a separate program, or a combination of both. State One chose a combined approach in which it expanded its Medicaid program and contracted with a third party to manage part of SCHIP.

## *Fee-for-Service Universes*

We were not able to reconcile the State's first- and fourth-quarter FFS universes to the Forms CMS-64 and CMS-21 data. Although we discussed our reconciliation with State officials and they provided additional information, we still were unable to reconcile the State's Forms CMS-64 and CMS-21 data to its FFS universes. The differences we identified during the reconciliation process are shown in Appendix A.

### **State Two**

We were not able to reconcile State Two's first- and fourth-quarter State Medicaid universes to its Forms CMS-64 data.<sup>8</sup> Because we were unable to reconcile the Form CMS-64 data to the State universes, we discussed our reconciliation with State officials. Although the State provided additional information, we still were unable to reconcile the State's Form CMS-64 data to its universes. The differences we identified during the reconciliation attempt are shown in Appendix B.

State officials informed us that they had problems with their managed care claims system. The system was originally designed only for FFS claims but was modified to handle managed care claims. As a result, the original FFS edits incorrectly voided managed care claims with errors. When a claim was voided, a new claim was or should have been submitted; however, nothing on the new claim tied it to the voided claim. This process resulted in three claims: the original claim, the voided claim, and the resubmission. Both the original claim and the resubmission were included in the PERM universe. As a result, the PERM universe may have been overstated. State officials could not provide any information on why the FFS universe did not reconcile.

### **State Three**

We were not able to reconcile State Three's first- and fourth-quarter universes to the Forms CMS-64 and CMS-21 data. The State informed us that the first quarter Medicaid and SCHIP universes would have to be combined for both managed care and FFS to reconcile to the Forms CMS-64 and CMS-21 data. During the reconciliation process, we found that some of the claims paid only with State funds, which should not have been included in the universe, were included in the first- and fourth-quarter universes. In addition, some claims that were paid with Federal funds and should have been included in the universe were excluded. We informed the statistical contractor, which determined that none of the claims paid only with State funds had been sampled and said that it would adjust the universes by removing these claims. The statistical contractor also determined that the claims excluded from the universes were not statistically significant and said that it would not take any actions to account for them. The differences we identified during the reconciliation process are shown in Appendix C.

### **State Four**

We were able to reconcile State Four's first- and fourth-quarter Medicaid and SCHIP combined universes to the Forms CMS-64 and CMS-21 data, but we were unable to reconcile the Forms

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<sup>8</sup> State Two's SCHIP program was exempt from the PERM because 2007 was the SCHIP program's first year.

CMS-64 and CMS-21 data to the State's four individual component universes. (Because of the method the State used to maintain accounting records and financial reports, we were unable to determine which amounts were Medicaid and which were SCHIP.) We discussed our reconciliation with the State, and although the State provided additional information, we still were unable to determine how the State obtained the individual universes for each component. The differences we identified during the reconciliation process are shown in Appendix D.

### **PRECISION LEVELS NOT MET FOR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

The PERM program's estimate of improper FY 2007 SCHIP payments did not meet the OMB-required precision level of plus or minus 2.5 percentage points at the 90-percent confidence interval or plus or minus 3 percentage points at the 95-percent confidence interval. The national SCHIP error rate was plus or minus 11.7 percentage points at 90-percent confidence.

CMS and the statistical contractor developed sample sizes that were intended to meet the OMB-required precision level of plus or minus 2.5 percentage points with a 90-percent confidence interval assuming a 7- to 8-percent error rate based on results from the PERM pilot. The overall error rates were substantially greater than anticipated, thus preventing CMS from meeting the IPIA precision requirements. The variation in the eligibility component of the SCHIP error rate across States was the predominant reason why the combined national error rate did not meet IPIA precision-level requirements. By including as errors cases for which States could not determine beneficiary eligibility, CMS found that some States had eligibility error rates of well over 10 percent while other States had error rates of under 5 percent. The substantial variation among the States with respect to their eligibility error rates directly affected the precision of the error rate. This result may indicate a need to adjust precision-level requirements for the SCHIP portion of the PERM review and to increase oversight of and outreach to the States with regard to eligibility verification procedures and handling undetermined cases in SCHIP.

### **INADEQUATE CLAIMS REPRICING CONTROLS**

CMS did not establish adequate controls to verify the accuracy of the States' repricing of claims that the review contractor determined to be partially in error. When the review contractor reviewed a claim, it determined that the claim had no error, had a partial error, or was completely in error. The review contractor sent claims with partial errors to the States for repricing to determine the amount in error. Of the 71 claims that had partial errors and were submitted to the States for repricing, we found the following:

- We identified 10 claims for which we disagreed with the States' repricing. We used the States' fee schedules and repricing methodology and determined that the States' repricing was incorrect.

- We were unable to verify the repricing amounts for 27 claims because the States either did not respond to our multiple requests for support for the repriced amounts or provided incorrect information.
- We identified two claims that did not need repricing, per the review contractor's review manual, and should not have been sent to the States.
- We verified that the remaining 32 claims were correctly repriced.

The review contractor's statement of work did not require verification of the accuracy of repriced claims, and the contractor did not assume the responsibility for such verification. Thus, the PERM program did not include sufficient internal controls to ensure the accuracy of repriced claims. CMS told us that they are considering requesting that States verify the accuracy of the repriced claims and submit documentation supporting the repricing. Under this plan, CMS will test repriced claims for accuracy. We agree and support CMS's efforts in taking this action.

Because we were unable to verify the repricing on all claims, we did not have enough information to determine the extent to which incorrect repricing affected the FY 2007 error rate estimate.

## **RECOMMENDATIONS**

We recommend that CMS:

- continue to work with the States, CMS Regional Offices, and the statistical contractor on reconciling the PERM universes to State financial reports;
- work with OMB to establish new precision-level requirements for PERM;
- request that the States verify the accuracy of all repriced claims and submit documentation supporting the repricing; and
- test repriced claims for accuracy.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its comments on our draft report, CMS agreed with our recommendations and proposed corrective actions. CMS's comments are included in their entirety as Appendix E.

# **APPENDIXES**

**APPENDIX A: STATE ONE RECONCILIATION**

**Managed Care Amounts Reported for the Payment Error Rate Measurement Program  
and on Forms CMS-64 and CMS-21 for Fiscal Year 2007**

	<b>Medicaid Managed Care 1st Quarter</b>	<b>Medicaid Managed Care 4th Quarter</b>	<b>SCHIP Managed Care (Expansion) 1st Quarter</b>	<b>SCHIP Managed Care (Expansion) 4th Quarter</b>	<b>SCHIP Managed Care (Stand-Alone) 1st Quarter</b>	<b>SCHIP Managed Care (Stand-Alone) 4th Quarter</b>
State universe	\$1,448,771,326	\$1,420,127,478	\$18,931,146	\$22,382,705	\$153,165,557	\$185,690,490
Forms CMS-64 and CMS-21 amounts	\$1,313,701,427	\$1,506,585,807	\$24,808,695	\$32,421,040	\$153,165,557	\$185,274,370
Difference	\$135,069,899	(\$86,458,329)	(\$5,877,549)	(\$10,038,335)	\$0	\$416,120
Difference as a percentage of Forms CMS-64 and CMS-21 amounts	10.3%	(5.7%)	(23.7%)	(31%)	0%	0.22%

**Fee-for-Service Amounts Reported for the Payment Error Rate Measurement Program  
and on Forms CMS-64 and CMS-21 for Fiscal Year 2007**

	<b>Medicaid FFS 1st Quarter</b>	<b>Medicaid FFS 4th Quarter</b>	<b>SCHIP FFS 1st Quarter</b>	<b>SCHIP FFS 4thQuarter</b>
State universe	\$5,933,702,920	\$6,161,779,411	\$146,683,983	\$145,894,937
Forms CMS-64 and CMS-21 amounts	\$4,954,541,697	\$5,608,528,863	\$112,386,994	\$121,486,956
Difference	\$979,161,223	\$553,250,548	\$34,296,989	\$24,407,981
Difference as a percentage of Forms CMS-64 and CMS-21 amounts	19.8%	9.9%	30.5%	20.1%

CMS = Centers for Medicare & Medicaid Services

SCHIP = State Children's Health Insurance Program (known as CHIP as of February 4, 2009)

FFS = fee-for-service

## APPENDIX B: STATE TWO RECONCILIATION

### Managed Care Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2007

	<b>Medicaid Managed Care 1st Quarter</b>	<b>Medicaid Managed Care 4th Quarter</b>
State universe	\$96,354,973	\$304,369,138
Form CMS-64 amount	\$100,980,522	\$299,153,998
Difference	(\$4,625,549)	\$5,215,140
Difference as a percentage of Form CMS-64 amount	(4.6%)	1.7%

### Fee-for-Service Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2007

	<b>Medicaid FFS 1st Quarter</b>	<b>Medicaid FFS 4th Quarter</b>
State universe	\$1,278,251,726	\$1,101,022,636
Form CMS-64 amount	\$1,528,386,013	\$1,413,054,439
Difference	(\$250,134,287)	(\$312,031,803)
Difference as a percentage of Form CMS-64 amount	(16.4%)	(22.1%)

**APPENDIX C: STATE THREE RECONCILIATION**

**Managed Care Amounts Reported for the Payment Error Rate Measurement Program  
and on Forms CMS-64 and CMS-21 for Fiscal Year 2007**

	<b>Medicaid and SCHIP Managed Care 1st Quarter</b>	<b>Medicaid Managed Care 4th Quarter</b>	<b>SCHIP Managed Care 4th Quarter</b>
State universe	\$37,427,111	\$43,161,304	\$1,450,151
Forms CMS-64 and CMS-21 amounts	\$40,743,257	\$39,431,446	\$1,577,489
Difference	(\$3,316,146)	\$3,729,858	(\$127,338)
Difference as a percentage of Forms CMS-64 and CMS-21 amounts	(8.1%)	9.5%	(8.1%)

**Fee-for-Service Amounts Reported for the Payment Error Rate Measurement Program  
and on Forms CMS-64 and CMS-21 for Fiscal Year 2007**

	<b>Medicaid and SCHIP FFS 1st Quarter</b>	<b>Medicaid FFS 4th Quarter</b>	<b>SCHIP FFS 4th Quarter</b>
State universe	\$814,330,420	\$762,690,995	\$8,609,467
Forms CMS-64 and CMS-21 amounts	\$815,637,866	\$749,961,300	\$7,873,030
Difference	(\$1,307,446)	\$12,729,695	\$736,467
Difference as a percentage of Forms CMS-64 and CMS-21 amounts	(0.2%)	1.7%	9.4%

The State informed us that the first-quarter Medicaid and SCHIP universes would have to be combined for both managed care and FFS to reconcile to the Forms CMS-64 and CMS-21 data.

**APPENDIX D: STATE FOUR RECONCILIATION**

**Fee-for-Service and Managed Care Amounts Reported for the  
Payment Error Rate Measurement Program  
and on Forms CMS-64 and CMS-21 for Fiscal Year 2007**

	<b>1st Quarter</b>	<b>4th Quarter</b>
State universe	\$380,756,047	\$398,314,534
Forms CMS-64 and CMS-21 amounts	\$398,379,016	\$400,727,823
Difference	(\$17,622,969)	(\$2,413,289)
Difference as a percentage of Forms CMS-64 and CMS-21 amounts	(4.4%)	(0.6%)

Because of the method the State used to maintain accounting records and financial reports, we were unable to determine which amounts were Medicaid and which were SCHIP. Therefore, we had to combine the Medicaid and SCHIP data into a single reconciliation.

**APPENDIX E: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

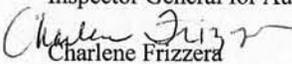
Centers for Medicare &amp; Medicaid Services

*Administrator*

Washington, DC 20201

**DATE:** MAR 24 2010

**TO:** Daniel R. Levinson  
Inspector General for Audit Services

**FROM:**   
Charlene Frizzera  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program" (A-06-08-00078)

Thank you for the opportunity to comment on the OIG draft report titled, "Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program (PERM)" (A-06-08-00078). We appreciate the OIG's review of the PERM program and its recommendations for program improvement. The Centers for Medicare & Medicaid Services (CMS) developed the PERM program to comply with the Office of Management and Budget's (OMB) requirement to measure improper payments in the Medicaid and State Children's Health Insurance Program (CHIP) programs.

The CMS has made a number of improvements to the PERM program, including implementing a two-step reconciliation process and requires more accountability from States. These efforts, in combination with the OIG's oversight and evaluation, provides CMS with vital feedback on PERM methodology and protocols that strengthen the PERM measurement and provide tools to help reduce the number and dollar amount of improper payments. These steps are enabling us and the States to better focus corrective actions to reduce improper payments.

**OIG Recommendation**

We recommend that CMS continue to work with the States, CMS Regional Offices, and the statistical contractor on reconciling the PERM universes to State financial reports.

**CMS Response**

The CMS concurs and has implemented reconciliation methodologies beginning with the FY 2009 measurement cycle. In order for the PERM measurement to be statistically valid, samples must be drawn from framed universes of States' claims data that are complete and accurate. Reconciling these universes with forms CMS-64 and CMS-21 is a way to ensure that universes are complete and accurate.

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To implement this recommendation, CMS has implemented a two-stage reconciliation process, as well as initiatives aimed at ensuring that State universe submissions are complete and accurate. The two-stage reconciliation process compares States' quarterly universe data submission to the financial reports, forms CMS-64 and CMS-21. In the first stage, we ask States to compare their quarterly universe data submission to the previous two quarters of the financial reports, forms CMS-64 and CMS-21. The previous two quarters of the forms CMS-64 and CMS-21 are used because the PERM universe data submissions are required prior to the time these reports are finalized. The first stage of this two-stage reconciliation allows States to identify, prior to universe data submission, sources of incomplete or inaccurate universe data. The second stage is a comparison, by the statistical contractor, of the current quarter's universe data with the current quarter's forms CMS-64 and CMS-21. In both stages of reconciliation, large differences between universe data and these reports are examined. We believe that this two-stage reconciliation process is working well, as percentage differences between expenditures and universe totals are uniformly in single digits. CMS intends to continue to refine and improve this reconciliation process in subsequent PERM measurement cycles.

**OIG Recommendation**

We recommend that CMS work with OMB to establish new precision-level requirements for PERM.

**CMS Response**

The CMS concurs and is currently seeking input from a variety of expert sources on methodological and statistical revisions to possibly propose to OMB.

**OIG Recommendation**

We recommend that CMS request the States to verify the accuracy of all repriced claims and submit documentation supporting the repricing.

**CMS Response**

The CMS concurs and, as explained in the following response, specifies the documentation needed to support the repriced amount. The methodology outlined will allow CMS to verify the accuracy of all repriced claims.

**OIG Recommendation**

We recommend that CMS test repriced claims for accuracy.

**CMS Response**

The CMS concurs and is implementing a testing methodology for repriced claims with the FY 2009 measurement. Specifically States are asked to submit "screen shots" showing the repriced payment amount. These screen shots will be sent to the review contractor. Senior data

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processing reviewers who have direct experience with the State's system will conduct the evaluation of the accuracy of this screen shot testing. If deemed successful, CMS will implement this methodology for all repriced claims in subsequent PERM cycles. CMS believes this methodology will satisfy the previous recommendation made by the OIG to verify the accuracy of repriced claims.

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