

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE CENTERS FOR MEDICARE
& MEDICAID SERVICES' ELIGIBILITY
REVIEW CONTRACTOR ADEQUATELY
DETERMINED MEDICAID ELIGIBILITY
FOR SELECTED STATES UNDER
THE PAYMENT ERROR RATE
MEASUREMENT PROGRAM**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Christi A. Grimm
Inspector General

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Office of Inspector General

<https://oig.hhs.gov>

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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.

Report in Brief

Date: March 2022

Report No. A-02-20-01006

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



Why OIG Did This Audit

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and the Children's Health Insurance Program and produce error rates for each program, including a review of the eligibility component of Medicaid. CMS recently made substantive changes to its PERM program, which included hiring a contractor to perform PERM eligibility reviews. In addition, prior OIG audits have identified Medicaid eligibility determinations as a high-risk area.

The objective of this audit was to assess the adequacy of the PERM program by determining whether CMS's contractor conducted eligibility reviews for selected States in accordance with Federal and State requirements.

How OIG Did This Audit

Our audit covered 1,311 Medicaid claims reviewed by CMS's eligibility review contractor, totaling over \$1.9 million (Federal share), included in the eligibility review component of the Reporting Year 2019 PERM program for 3 States. We judgmentally selected these States based on various factors, including total Medicaid payments, individual State eligibility error rates, and the types of eligibility errors identified by CMS's eligibility review contractor. We reviewed a random sample of 100 Medicaid claims (total) for the 3 States.

The Centers for Medicare & Medicaid Services' Eligibility Review Contractor Adequately Determined Medicaid Eligibility for Selected States Under the Payment Error Rate Measurement Program

What OIG Found

We determined that CMS's eligibility review contractor correctly determined Medicaid eligibility for the beneficiaries associated with all 100 sampled claims. Based on our sample results, we concluded that CMS's eligibility review contractor adequately determined Medicaid eligibility for three States (Connecticut, Pennsylvania, and Virginia) under CMS's PERM program in accordance with Federal and State requirements.

Accordingly, this report contains no recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing States' design and operation of their Medicaid programs and ensuring that Federal funds are appropriately spent. CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and the Children's Health Insurance Program (CHIP) and produce error rates for each program based on reviews of the fee-for-service, managed care, and eligibility components of Medicaid and CHIP in the year under review. CMS recently made substantive changes to its PERM program that incorporated changes mandated by the Affordable Care Act (ACA).¹ CMS also hired a contractor to perform PERM eligibility reviews. In addition, prior Office of Inspector General (OIG) audits have identified Medicaid eligibility determinations as a high-risk area.² These audits found that States did not always correctly determine Medicaid eligibility for Medicaid beneficiaries. This is the first in a series of three OIG audits that will assess the adequacy of the PERM program by reviewing the accuracy of determinations for each of its three programs.³

OBJECTIVE

The objective of this audit was to assess the adequacy of the PERM program by determining whether CMS's contractor conducted eligibility reviews for selected States in accordance with Federal and State requirements.⁴

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, States must cover certain population groups. The Federal and State Governments jointly fund and administer the Medicaid program. Generally, individual eligibility criteria are met by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of U.S. citizenship. For many

¹ The Patient Protection and Affordable Act, P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), is known as the Affordable Care Act.

² See Appendix B for a list of prior OIG reports.

³ Specifically, for this audit, we reviewed the eligibility component of the PERM program. Subsequent audits will review the fee-for-service and managed care components of the PERM program.

⁴ The selected States for our audit were Connecticut, Pennsylvania, and Virginia. We judgmentally selected these States based on various factors, including total Medicaid payments, individual State eligibility error rates, and the types of eligibility errors identified by CMS's eligibility review contractor.

eligibility groups, financial eligibility is determined in relation to a percentage of the Federal Poverty Level (FPL).

States operate and fund Medicaid in partnership with the Federal Government through CMS. CMS reimburses States for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP), which is developed from criteria such as States' per capita income.⁵ The standard FMAP varies by State and ranged from 50 to 75.65 percent during our audit period.⁶

Medicaid Coverage and Changes to Medicaid Eligibility Rules Under the Affordable Care Act

Beginning in 2014, the ACA provided States with the authority to expand their Medicaid programs to cover more low-income people, including adults without dependent children who were not previously eligible, formerly referred to as the "new adult group."⁷ In States that elected to expand their programs under the ACA, individuals were eligible for Medicaid under the new adult group if they met certain criteria, such as age (not being younger than 19 or older than 64 years of age) and income (not having an income exceeding 133 percent of the FPL)⁸ in addition to meeting citizenship and State residency⁹ requirements.

The ACA also required each State to establish its own health insurance exchange (marketplace) or elect to operate through the CMS-administered Federal marketplace. A marketplace is designed to serve as a "one-stop shop" where individuals can review their health insurance options and are evaluated for Medicaid eligibility. Further, States were required to make several changes to their Medicaid application and enrollment processes. Changes included requiring States to use a single, streamlined enrollment application that facilitated screening an individual's eligibility for all potential health coverage options (e.g., Medicaid, CHIP, and qualified health plans) available through the marketplaces.¹⁰ Finally, in many cases, the ACA

⁵ Social Security Act (the Act) § 1905(b).

⁶ 80 Fed. Reg. 73779 (Nov. 25, 2015) and 81 Fed. Reg. 80078 (Nov. 15, 2016).

⁷ ACA § 2001(a)(1)(C).

⁸ 42 CFR § 435.119(b)(5). Section 1902 of the Act established the FPL threshold at 133 percent but allows for what is known as a "5-percent income disregard," making the effective threshold 138 percent of the FPL.

⁹ 42 CFR §§ 435.403 and 435.406.

¹⁰ ACA § 1413(b).

required States to use a methodology based on Modified Adjusted Gross Income (MAGI) to determine a person's income.¹¹

Section 2001 of the ACA authorized an FMAP of 100 percent for qualified expenditures incurred by States on behalf of newly eligible beneficiaries enrolled in the new adult group.¹² This "newly eligible FMAP" was set at 100 percent through 2016 and gradually decreased to 90 percent by 2020. As of November 2021, it remains at 90 percent.¹³

Medicaid Eligibility Verification Requirements

States must maintain individual records on each applicant and beneficiary that are essential to determining initial and continuing Medicaid eligibility.¹⁴ States are required to have an income and eligibility verification system for determining Medicaid eligibility, and upon CMS's request, a verification plan describing the State agency's policies and procedures for implementing the eligibility verification requirements.¹⁵ States must verify individuals' eligibility information, such as citizenship or lawful presence, and entitlement to, or enrollment in, Medicare, through electronic sources.¹⁶ States may accept an individual's attestation for certain information, such as pregnancy status and household composition (e.g., household size and family relationships), without further verification.¹⁷

CMS Programs to Review States' Medicaid Eligibility Determinations

CMS and States monitor and assess the accuracy of Medicaid eligibility determinations using the PERM and Medicaid Eligibility Quality Control (MEQC) programs. In July 2017, CMS published a final rule that modified PERM and MEQC requirements to incorporate changes

¹¹ The Act §§ 1902(e)(14)(A)-(D). Certain individuals, such as seniors aged 65 and older and medically needy individuals, are exempt from the use of this methodology. Adjusted gross income, or AGI, is an individual's total income for the year, minus certain adjustments such as Individual Retirement Account contributions and student loan interest. MAGI is AGI plus untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

¹² The Act § 1905(y)(2)(A) defines a "newly eligible" beneficiary as "an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the ACA, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage."

¹³ 42 CFR § 433.10(c)(6).

¹⁴ 42 CFR § 431.17.

¹⁵ The Act §§ 1137(a) and (b); 42 CFR § 435.945(j).

¹⁶ 42 CFR §§ 435.945(a) and (b) and 435.949.

¹⁷ 42 CFR §§ 435.945(a) and 435.956.

mandated by the ACA.¹⁸ One modification involved CMS hiring a contractor to perform PERM eligibility reviews.¹⁹

The PERM program uses a 3-year rotational cycle to produce and report the Medicaid improper payment rate. Each cycle examines the Medicaid program of 17 States.²⁰ Cycle 1 covered Medicaid payments made from July 1, 2017, through June 30, 2018 (Reporting Year (RY) 2019), and included the following States: Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, and Wyoming. For these reviews, CMS utilized: (1) a statistical contractor responsible for collecting and sampling fee-for-service claims and managed care capitation payment data, as well as calculating Medicaid State and national improper payment rates; (2) a review contractor responsible for conducting State data processing and medical record reviews for the PERM program; and (3) an eligibility review contractor responsible for conducting State eligibility reviews for the PERM program. CMS's eligibility review contractor determined that the Medicaid eligibility error rate (national) under the PERM program for RY 2019 was 20.60 percent. For our selected States, the contractor determined that the Medicaid eligibility error rates were 35.09 percent (Connecticut), 11.36 percent (Pennsylvania), and 3.51 percent (Virginia).

After the conclusion of the contractors' PERM reviews, States must develop a corrective action plan to address any findings. States must also conduct an MEQC review during the 2-year interval between their designated PERM review period and submit to CMS a corrective action plan to address any errors and deficiencies found during their MEQC review.²¹ Also, CMS revised Federal regulations to allow it to disallow the Federal share of Medicaid payments associated with eligibility errors detected through PERM reviews after July 1, 2020.²²

HOW WE CONDUCTED THIS AUDIT

Our audit covered 1,311 Medicaid claims reviewed by CMS's eligibility review contractor, totaling \$3,372,346 (\$1,936,385 Federal share), included in the eligibility review component of

¹⁸ 82 Fed. Reg. 31158 (July 5, 2017), [Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act](#).

¹⁹ CMS contracted with Booz Allen Hamilton, Inc., to be the eligibility review contractor that conducted State eligibility reviews for the PERM program.

²⁰ The PERM program examines the 50 States and the District of Columbia as part of its 3-year rotational cycle.

²¹ Under the MEQC program, States design and conduct reviews to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP. States have flexibility in designing their reviews to identify vulnerable or error-prone areas; however, the MEQC program does not determine an error rate.

²² 42 CFR § 431.1010.

the RY 2019 PERM program for three Cycle 1 States—Connecticut, Pennsylvania, and Virginia.²³ We reviewed a random sample of 100 Medicaid claims (total) for the 3 States totaling \$277,748 (\$149,628 Federal share).

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

Appendix A contains the details of our audit scope and methodology.

RESULTS OF AUDIT

We determined that CMS's eligibility review contractor correctly determined Medicaid eligibility for the beneficiaries associated with all 100 sampled claims. Based on our sample results, we concluded that CMS's eligibility review contractor adequately determined Medicaid eligibility for three States (Connecticut, Pennsylvania, and Virginia) under CMS's PERM program in accordance with Federal and State requirements.

Accordingly, this report contains no recommendations.

²³ We judgmentally selected these States based on various factors, including total Medicaid payments, individual State eligibility error rates, and the types of eligibility errors identified by CMS's eligibility review contractor.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

This audit covered 1,311 Medicaid claims totaling \$3,372,346 (\$1,936,385 Federal share) that were included in the eligibility review component of the RY 2019 PERM program for 3 Cycle 1 States—Connecticut, Pennsylvania, and Virginia. We judgmentally selected the States based on various factors, including total Medicaid payments, individual State eligibility error rates, and the types of eligibility errors identified by CMS’s eligibility review contractor. We reviewed a random sample of 100 Medicaid claims (total) for the 3 States totaling \$277,748 (\$149,628 Federal share)—Connecticut (15 claims), Pennsylvania (54 claims), and Virginia (31 claims).

We limited our review of internal controls to those applicable to our objective. Specifically, we tested controls to confirm that the Medicaid eligibility review contractor’s policies and procedures for determining Medicaid eligibility were operating as intended and reviewed supporting documentation to evaluate whether they determined Medicaid eligibility in accordance with Federal and State requirements.

We performed our audit work from April 2020 through November 2021.

METHODOLOGY

To accomplish the objective for this audit, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to the PERM program and Medicaid eligibility;
- met with CMS officials to obtain an understanding of the PERM program and recent changes made to the program;
- met with CMS’s statistical contractor to obtain an understanding of the payment data submitted by States for the PERM program, the contractor’s quality review of those data, and the eligibility review sampling process;
- obtained the sample of payments selected by the statistical contractor for the PERM program’s RY 2019 eligibility review;
- met with CMS’s eligibility review contractor to obtain an understanding of the contractor’s eligibility review process;
- obtained Medicaid eligibility requirements and policies that the eligibility review contractor used in its PERM eligibility review of Cycle 1 States;

- selected a random sample of Medicaid claims from CMS’s statistical contractor’s RY 2019 sample for the three States included in our audit;
- obtained and reviewed case file documentation from CMS’s eligibility review contractor for each sampled claim to determine:
 - if sufficient information was provided to determine the associated beneficiary’s Medicaid eligibility and
 - whether the eligibility determination was made in accordance with Federal and State eligibility requirements;
- compared our eligibility determinations with those of CMS’s eligibility review contractor to determine whether the contractor’s Medicaid eligibility review met Federal PERM requirements; and
- discussed the results of our review with CMS officials.

We provided CMS with a draft report on January 3, 2022, for review. CMS elected not to provide formal comments; however, it provided technical comments, which we addressed as appropriate.

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

APPENDIX B: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Louisiana Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-06-18-02000</u>	1/27/2021
<i>Ohio Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-05-18-00027</u>	11/10/2020
<i>Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place</i>	<u>A-07-18-02812</u>	3/24/2020
<i>Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-07-16-04228</u>	8/30/2019
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries</i>	<u>A-02-16-01005</u>	7/17/2019
<i>California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<u>A-09-17-02002</u>	12/11/2018
<i>California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<u>A-09-16-02023</u>	02/20/2018
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-02-15-01015</u>	1/5/2018
<i>Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements</i>	<u>A-04-16-08047</u>	8/17/2017
<i>Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-04-15-08044</u>	5/10/2017