

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE CENTERS FOR MEDICARE &  
MEDICAID SERVICES' REVIEW  
CONTRACTORS GENERALLY CONDUCTED  
MEDICAID FEE-FOR-SERVICE CLAIM  
REVIEWS FOR SELECTED STATES UNDER  
THE PAYMENT ERROR RATE  
MEASUREMENT PROGRAM IN  
ACCORDANCE WITH FEDERAL AND  
STATE REQUIREMENTS**

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# ***Office of Inspector General***

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## Report in Brief

Date: November 2022

Report No. A-04-21-00132

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



### Why OIG 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). This is the second 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 components.

The objective of this audit was to assess the adequacy of the PERM program by determining whether CMS's contractors conducted Medicaid fee-for-service (FFS) reviews in accordance with Federal and State requirements.

### How OIG Did This Audit

Our audit covered 1,653 Medicaid FFS claims reviewed by CMS's PERM contractors, totaling over \$2.9 million (Federal share), included in the Medicaid FFS 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 FFS error rates, and the types of errors identified by CMS's review contractors. We reviewed a random sample of 100 Medicaid FFS claims (total) for the 3 States.

## The Centers for Medicare & Medicaid Services' Review Contractors Generally Conducted Medicaid Fee-for-Service Claim Reviews for Selected States Under the Payment Error Rate Measurement Program in Accordance with Federal and State Requirements

### What OIG Found

CMS's contractors generally conducted Medicaid FFS reviews in accordance with Federal and State requirements. Of the 100 sampled Medicaid PERM FFS claims we reviewed, 90 claims were correctly determined and adequately documented. However, claim review determinations for the remaining 10 claims were not documented and therefore may be incorrect. Based on our sample results, we estimated that 10 percent of the sampled Medicaid FFS claims reviewed by CMS's contractors were not documented and claim review determinations for these claims may not have been correct. We also estimated the total amount paid related to these claims to be \$6,411 (Federal share) during our audit period.

CMS's contractors did not always maintain documentation of their claim review determinations because CMS did not include specific contract language requiring its contractors to maintain all documentation to support the contractors' Medicaid FFS claim review determinations for non-error claims.

We are not making recommendations because CMS took action to address the deficiencies we identified. Additionally, our sample estimates indicated that these potential errors were immaterial when applied to our sampling frame.

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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. In response to the Improper Payments Information Act of 2002 (P.L. No. 107-300), CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and the Children's Health Insurance Program (CHIP) and estimate national improper payment rates for each program based on reviews of the fee-for-service (FFS), 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 various changes, including those mandated by the Affordable Care Act.<sup>1</sup> CMS used PERM FFS review contractors (review contractors) to perform Medicaid PERM FFS reviews (FFS reviews). This is the second in a series of three OIG audits<sup>2</sup> that will assess the adequacy of the PERM program by reviewing the accuracy of determinations for each of its three components.<sup>3</sup>

### OBJECTIVE

The objective of this audit was to assess the adequacy of the PERM program by determining whether CMS's contractors conducted FFS reviews in accordance with Federal and State requirements.<sup>4</sup>

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<sup>1</sup> The Patient Protection and Affordable Care 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. 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*.

<sup>2</sup> The first audit, *The Centers for Medicare & Medicaid Services' Eligibility Review Contractor Adequately Determined Medicaid Eligibility for Selected States Under the Payment Error Rate Measurement Program (A-02-20-01006)*, was issued Mar. 2, 2022.

<sup>3</sup> Specifically, for this audit, we reviewed the FFS component of the PERM program. Other audits reviewed the eligibility and managed care components of the PERM program.

<sup>4</sup> The selected States for our audit were Arkansas, Connecticut, and New Mexico. We judgmentally selected these States based on various factors, including total Medicaid payments, individual State FFS error rates, and the types of errors identified by CMS's review contractors.

## **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.

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.<sup>5</sup> The standard FMAP for our selected States during our audit period ranged from 50 to 71.13 percent.<sup>6</sup>

States may offer Medicaid benefits on an FFS basis, through managed care organizations (MCO), or both. Under the FFS model, States directly pay providers for each covered service received by a Medicaid beneficiary. In general, States may set provider payments under the FFS model. Section 1902(a)(30)(A) of the Social Security Act requires that such payments be consistent with efficiency, economy, and quality of care, and are sufficient to provide access equivalent to the general population in the geographic area. Under the managed care model, States contract with MCOs to make services available to enrolled Medicaid beneficiaries, usually in return for capitation payments.

### **Medicaid Payment Error Rate Measurement Reviews**

The PERM program uses a 3-year rotational cycle to estimate national improper payment rates in Medicaid and CHIP. Each cycle examines the Medicaid program of 17 States.<sup>7</sup> 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 Medicaid PERM FFS claims (PERM FFS claims) and managed care capitation payment data, as well as calculating Medicaid State and national improper payment rates; (2) a FFS review contractor responsible for conducting data processing and medical record reviews for the PERM program;<sup>8</sup> and (3) an eligibility review contractor responsible for conducting State eligibility reviews for the PERM program.

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<sup>5</sup> Social Security Act (the Act) § 1905(b).

<sup>6</sup> 80 Fed. Reg. 73779 (Nov. 25, 2015).

<sup>7</sup> The PERM program examines the 50 States and the District of Columbia as part of its 3-year rotational cycle.

<sup>8</sup> During our audit period, CMS used two review contractors. One contractor performed data-processing reviews and another contractor performed medical record reviews.

CMS estimated that the Medicaid FFS error rate (national) under the PERM program for RY 2019 was 16.3 percent. For our selected States, CMS estimated that the Medicaid FFS error rates were 17.94 percent (Arkansas), 13.48 percent (Connecticut), and 48.86 percent (New Mexico). After the conclusion of the contractors' PERM reviews, States must develop a corrective action plan to address any findings.

### **Medicaid Payment Error Rate Measurement Fee-For-Service Reviews**

Review contractors are responsible for conducting data processing and medical record reviews for the PERM program. Accordingly, they are responsible for researching, requesting, and collecting applicable Federal regulations under Title 42 of the Code of Federal Regulations, and State medical and claims payment policies from States' publicly available websites.

All PERM FFS claims go through a data processing review. After a review contractor receives the PERM FFS claims from the statistical contractor, it schedules data processing reviews with each of the selected States. The data processing reviews include examining line items in each PERM FFS claim to validate that the State processed the claim correctly. If there is a specific service requiring the review contractor to make a medical necessity determination, the claim also goes through a medical record review, and the review contractor contacts the associated providers to obtain copies of medical records for the PERM FFS claims. The review contractor then examines the associated medical record to ensure documentation supports the claim billed, medical necessity, and coding accuracy.

### **HOW WE CONDUCTED THIS AUDIT**

Our audit covered 1,653 PERM FFS claims, totaling \$4,093,597 (\$2,942,003 Federal share), that were reviewed by CMS's review contractors and included in the RY 2019 PERM program for 3 Cycle 1 States—Arkansas, Connecticut, and New Mexico.<sup>9</sup> We reviewed a random sample of 100 of these claims totaling \$203,807 (\$153,311 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.

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<sup>9</sup> We judgmentally selected these States based on various factors, including total Medicaid payments, individual State FFS error rates, and the types of errors identified by CMS's review contractors.



## FINDINGS

CMS's review contractors generally conducted FFS reviews in accordance with Federal and State requirements. Of the 100 sampled PERM FFS claims we reviewed, 90 claims were correctly determined and adequately documented. However, claim review determinations for the remaining 10 claims were not documented and therefore may be incorrect.<sup>10</sup> Based on our sample results, we estimated that 10 percent of the PERM FFS claims reviewed by CMS's review contractors were not documented and claim review determinations for these claims may not have been correct. We also estimated the total amount paid related to these claims to be \$7,529 (\$6,411 Federal share) during our audit period.<sup>11</sup>

The Office of Management and Budget (OMB) provides guidance to Federal agencies on estimating improper payments. According to OMB M-18-20, Circular A-123, Appendix C, when designing their internal control framework for managing payment integrity, Federal agencies should consult the GAO *Green Book*, which states that documentation is a necessary part of an effective internal control system. CMS's review contractors did not always maintain documentation of their claim review determinations because CMS did not include specific contract language requiring its review contractors to maintain all documentation to support their Medicaid FFS claim review determinations for non-error claims.

We concluded that CMS's review contractors adequately conducted FFS claim reviews for three States (Arkansas, Connecticut, and New Mexico) under CMS's PERM program in accordance with Federal and State requirements.

We are not making recommendations because CMS took action to address the deficiencies we identified. After our audit period, in October 2019, CMS added contract language requiring the contractors to maintain relevant documentation for non-error (i.e., correct) claims. Thus, CMS took action to mitigate such errors going forward. Additionally, our sample estimates indicated that these potential errors were immaterial when applied to our sampling frame.

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<sup>10</sup> All 10 of these claims were low dollar claims determined by the review contractors to be non-errors. Of these 10 claims, 9 were not subjected to medical review. The review contractors did not maintain documentation of their claim determinations; therefore, we could not determine if the review contractors reviewed the claims in accordance with Federal and State requirements. In accordance with our approved sampling plan, we treated these claims as errors (i.e., incorrect claim review determinations).

<sup>11</sup> Appendix B describes our statistical sampling methodology and Appendix C contains our sample results and estimates.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

This audit covered 1,653 PERM FFS claims totaling \$4,093,597 (\$2,942,003 Federal share) that were included in the Medicaid FFS component of the RY 2019 PERM program for 3 Cycle 1 States—Arkansas, Connecticut, and New Mexico. We judgmentally selected these States based on various factors, including total Medicaid payments, individual State FFS error rates, and the types of errors identified by CMS’s review contractors. We reviewed a random sample of 100 PERM FFS claims (total) for the three States totaling \$203,807 (\$153,311 Federal share)—Arkansas (44 claims), Connecticut (34 claims), and New Mexico (22 claims).

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

We performed our audit work from December 2020 through October 2022.

### METHODOLOGY

To accomplish the objective for this audit, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to the PERM program;
- discussed the PERM program with CMS officials in order to obtain an understanding of the program and recent changes made to the program;
- obtained documentation related to the review contractors’ FFS claim reviews for Cycle 1 States;
- selected a random sample of PERM FFS claims from CMS’s RY 2019 PERM program for the three States included in our audit;
- obtained and reviewed supporting file documentation from CMS’s review contractors for each PERM FFS claim in our sample to determine whether the review contractors correctly identified claims that were not paid in accordance with Federal and State requirements, including identifying claims as in accordance or not in accordance with these requirements when the sample file did not contain sufficient information to make a determination; and

- discussed the results of our review with CMS officials.

We provided CMS with a draft report on October 17, 2022, for review. CMS elected to not 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: STATISTICAL SAMPLING METHODOLOGY**

### **SAMPLING FRAME**

The sampling frame consisted of an Excel file containing 1,653 Medicaid claims totaling \$4,093,597 (\$2,942,003 Federal share) that were included in the Medicaid FFS component of the RY 2019 PERM program for 3 Cycle 1 States: Arkansas, Connecticut, and New Mexico.<sup>12, 13</sup>

### **SAMPLE UNIT**

The sample unit was a Medicaid PERM FFS claim.

### **SAMPLE DESIGN AND SAMPLE SIZE**

We used a simple random sample of 100 PERM FFS claims.

### **SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

### **METHOD OF SELECTING SAMPLE ITEMS**

We sorted the items in the sampling frame by PERM ID and then consecutively numbered the sample items. After generating the random numbers, we selected the corresponding frame items.

### **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the percentage and total dollar amount of PERM FFS claims in the sampling frame for which the review contractors made an incorrect FFS payment determination, including when the case file did not contain sufficient information for a determination.

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<sup>12</sup> We judgmentally selected these States based on various factors, including total Medicaid payments, individual State FFS error rates, and the types of errors identified by CMS's review contractors.

<sup>13</sup> Each PERM FFS claim represents a Medicaid payment made between July 1, 2017, and June 30, 2018, for which CMS's review contractors determined whether the State paid the claim in accordance with State and Federal requirements, the results of which were used to calculate the FFS Improper Payment Error Rate.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 1: Sample Details and Results**

	<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Incorrect Payment Determinations in Sample</b>	<b>Value of Incorrect Payment Determinations in Sample</b>
<b>Total</b>	1,653	\$4,093,597	100	\$203,807	10	\$456

**Table 2: Sample Details and Results (Federal Share)**

	<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Incorrect Payment Determinations in Sample</b>	<b>Value of Incorrect Payment Determinations in Sample</b>
<b>Total</b>	1,653	\$2,942,003	100	\$153,311	10	\$388

**Table 3: Estimated Incorrect Payment Determinations in the Sampling Frame  
(Limits Calculated at the 90-Percent Confidence Level)**

	<b>Point Estimate</b>	<b>Lower Limit</b>	<b>Upper Limit</b>
Total value	\$7,529	\$1,689	\$13,370
Federal share	\$6,411	\$1,246	\$11,576

**Table 4: Estimated Percentage of Incorrect Payment Determinations in the Sampling Frame  
(Limits Calculated at the 90-Percent Confidence Level)**

	<b>Point Estimate</b>	<b>Lower Limit</b>	<b>Upper Limit</b>
Percentage	10.00%	5.69%	16.15%