

March 2013

MEDICAID

Enhancements Needed for Improper Payments Reporting and Related Corrective Action Monitoring



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Why GAO Did This Study

Medicaid has the second-highest estimated improper payments of any federal program that reported such data for fiscal year 2011. Also, the Congress has raised questions about reporting and corrective actions related to the Medicaid program's improper payments. The objectives of this report were to determine the extent to which (1) CMS's methodology for estimating Medicaid improper payments follows OMB guidance and produces reasonable national and state-level estimates and (2) corrective action plans have been developed to reduce Medicaid payment error rates and whether these plans address the types of payment errors identified. To address these objectives, GAO analyzed CMS's policies and procedures against federal guidance and standards for estimating improper payments and developing related corrective actions to address errors. GAO also reviewed the results of all state-level reviews and conducted site visits at selected states that either received relatively large amounts of Medicaid payments or had varying rates of estimated improper payments, including states with possible best practices. GAO also met with cognizant CMS officials and contractors.

What GAO Recommends

GAO is making four recommendations to help improve CMS's reporting of estimated Medicaid improper payments and its related corrective action process. The Department of Health and Human Services concurred with GAO's recommendations and cited a number of actions under way and planned.

View [GAO-13-229](#). For more information, contact Beryl H. Davis at (202) 512-2623 or davisbh@gao.gov.

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What GAO Found

The Centers for Medicare & Medicaid Services' (CMS) methodology for estimating a national improper payment rate for the Medicaid program is statistically sound. However, CMS's procedures did not provide for updating state data used in its methodology to recognize significant corrections or adjustments after the cutoff date. The Office of Management and Budget (OMB) requires that federal agencies establish a statistically valid methodology for estimating the annual amount of improper payments in programs and activities susceptible to significant improper payments. CMS developed the Payment Error Rate Measurement (PERM) program in order to comply with improper payment estimation and reporting requirements for the Medicaid program. Under the PERM methodology, CMS places states in one of three cycles, and each year one of the cycles reports new state-level data based on the previous year's samples. CMS then calculates the national Medicaid program improper payment estimate using these new data for one-third of the states and older data for the other two-thirds of the states. CMS's estimated national improper payment error rate for fiscal year 2011 for the Medicaid program was 8.1 percent, or \$21.9 billion. However, CMS's procedures did not provide for considering revisions to state-level Medicaid program error rates used in the CMS methodology for calculating its national Medicaid program error rate. Because corrections to the 2 years of older data after the cutoff date are not officially recognized by CMS, the entire 3-year cycle could be affected. OMB has identified as a best practice that agencies should establish a policy for handling unscheduled corrections to data. Until CMS establishes procedures for considering changes to initially reported state-level error rates that would be significant to the national error rate, CMS is impaired in its ability to ensure that its reported estimate of the extent of national Medicaid improper payments is reliable.

CMS and state agencies developed corrective action plans (CAP) related to identified PERM payment errors. However, GAO identified the following areas where improvements were needed in CMS's written guidance to states on CAPs to ensure efficient and effective actions to reduce improper payments.

- CMS's PERM Manual did not clearly identify the circumstances under which states should consider, and if cost effective include, nonpayment errors (such as certain coding errors that could have but did not result in a payment error) and minimal dollar errors in their CAPs.
- The PERM Manual and the associated website did not provide complete and consistent information on the required elements to include in a state CAP.
- CMS guidance did not clearly delineate CMS officials' roles and responsibilities for conducting oversight of (1) state CAP submissions to ensure that they contained all of the required elements and adequately addressed errors identified in the PERM reviews and (2) states' progress in implementing CAP corrective actions.

Although the nonpayment errors identified in PERM reviews did not result in improper payments, the underlying issues may result in improper payments in future years if not addressed. Also, complete information in state CAPs is necessary for CMS to analyze the progress and effectiveness of the CAPs. Further, clear accountability for continuous monitoring helps ensure that actions are taken to effectively reduce Medicaid improper payments.

Contents

Letter		1
	Background	6
	Estimate of National Medicaid Improper Payments Did Not Consider Revised Individual State Error Rates	11
	Deficiencies in CMS's Guidance and Monitoring Impair Efficient and Effective Medicaid Program Improper Payments Reductions	15
	Conclusions	28
	Recommendations for Executive Action	29
	Agency Comments and Our Evaluation	29
Appendix I	Objectives, Scope, and Methodology	32
Appendix II	Fee-for-Service, Managed Care, and Eligibility Components of the Medicaid Error Rate Measurement	36
Appendix III	State Error Rates for the Department of Health and Human Services' Fiscal Year 2011 Reporting of Medicaid Improper Payments	39
Appendix IV	Medicaid Outlays and Estimated Improper Payment Error Rates Reported by the Department of Health and Human Services	42
Appendix V	Additional Details for Medicaid Error Rates	43
Appendix VI	Types of Errors Identified in Payment Error Rate Measurement Reviews	44

Appendix VII	Comments from the Department of Health and Human Services	46
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Appendix VIII	GAO Contact and Staff Acknowledgments	55
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Tables

Table 1: CMS's Corrective Action Strategies to Reduce PERM-Identified Improper Payments	19
Table 2: State Error Rates Used to Determine HHS's Fiscal Year 2011 Reporting of National Medicaid Improper Payments	40
Table 3: Medicaid Outlays and Estimated Improper Payment Error Rates Reported in HHS's AFRs	42
Table 4: Margins of Error for Error Rate Data Presented in Figure 2	43
Table 5: Summary of Errors, Fiscal Years 2008 to 2010 PERM Measurement Cycles	44

Figures

Figure 1: PERM Process for Estimating and Reducing Medicaid Improper Payments for Fiscal Year 2011 Reporting	7
Figure 2: Medicaid Error Rate Calculation for Fiscal Year 2011 Reporting	10
Figure 3: Types of Errors Identified in the Fiscal Years 2008 to 2010 PERM Measurement Cycles Based on Number of Errors	17
Figure 4: CMS's Regulatory Requirements for States to Develop CAPs to Reduce Improper Payments	24

Abbreviations

AFR	agency financial report
CAP	corrective action plan
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
DERM	Division of Error Rate Measurement
FFS	fee-for-service
HHS	Department of Health and Human Services
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPIA	Improper Payments Information Act of 2002
MIG	Medicaid Integrity Group
OMB	Office of Management and Budget
PERM	Payment Error Rate Measurement

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United States Government Accountability Office
Washington, DC 20548

March 29, 2013

The Honorable Thomas R. Carper
Chairman
The Honorable Tom Coburn, M.D.
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Claire McCaskill
Chairman
Subcommittee on Financial and Contracting Oversight
Committee on Homeland Security and Governmental Affairs
United States Senate

Medicaid has the second-highest estimated improper payments of any federal program that reported such data for fiscal year 2011.¹ In its fiscal year 2011 agency financial report (AFR), the Department of Health and Human Services (HHS) reported estimated improper payments for Medicaid of about \$21.9 billion, based on an error rate of 8.1 percent,² which contributed to the total governmentwide improper payment estimate of over \$115 billion for that year.

¹An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation was found. It is important to recognize that improper payment estimates reported by federal agencies are not intended to be an estimate of fraud in federal agencies' programs and activities.

²According to the Centers for Medicare & Medicaid Services (CMS), the estimated error rate of 8.1 percent for fiscal year 2011 has a margin of error at the 90 percent confidence level of no more than plus or minus 2.2 percentage points. The reported estimate of Medicaid improper payments for fiscal year 2012 is \$19.2 billion based on an estimated error rate of 7.1 percent. According to CMS, the estimated error rate of 7.1 percent for fiscal year 2012 has a margin of error at the 90 percent confidence level of no more than plus or minus 2.0 percentage points. HHS's fiscal year 2012 AFR was issued in November 2012. Because of the timing of our engagement, the fiscal year 2012 improper payment data were not included in our review.

The size and diversity of the Medicaid program make it particularly vulnerable to improper payments—including payments made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided. Medicaid, the joint federal-state health care financing program for certain low-income individuals, is one of the largest social programs in federal and state budgets, providing care to about 70 million individuals at a cost of \$436 billion in fiscal year 2011.³ The Centers for Medicare & Medicaid Services (CMS), a federal agency within HHS, is responsible for overseeing the program at the federal level, while the states administer their respective programs' day-to-day operations.

We designated Medicaid as a high-risk program in 2003 in part because of concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending.⁴ Medicaid remains at high risk because of concerns about the adequacy of fiscal oversight of this large, diverse, and growing program. We have specifically identified improper payments to Medicaid providers serving program beneficiaries as an area of concern. Given the hundreds of billions of dollars disbursed annually for the Medicaid program, improper payments to providers that submit inappropriate claims can result in substantial financial losses to states and the federal government.

As required under the Improper Payments Information Act of 2002 (IPIA),⁵ as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA),⁶ HHS has identified its programs that are susceptible to significant improper payments, including Medicaid. IPIA, as amended, requires agencies to obtain a statistically valid estimate, or an estimate

³The federal government matches states' expenditures for most Medicaid services using a statutory formula based on each state's per capita income. The federal share of Medicaid expenditures typically ranges from 50 to 83 percent. In fiscal year 2011, the federal share of Medicaid spending was \$275 billion, while the state share was \$161 billion.

⁴GAO, *High-Risk Series: An Update*, [GAO-13-283](#) (Washington, D.C.: February 2013).

⁵Pub. L. No. 107-300, 116 Stat. 2350 (Nov. 26, 2002), *codified, as amended*, at 31 U.S.C. § 3321 note.

⁶Pub. L. No. 111-204, 124 Stat. 2224 (July 22, 2010), *codified, as amended*, at 31 U.S.C. § 3321 note. The changes made by this law to IPIA estimation and reporting were first implemented for fiscal year 2011 reporting. IPIA and IPERA were further amended in January 2013 by the Improper Payments Elimination and Recovery Improvement Act, Pub. L. No. 112-248, 126 Stat. 2390 (Jan. 10, 2013).

that is otherwise appropriate using a methodology approved by the Office of Management and Budget (OMB), of the annual amount of improper payments in such programs. OMB has issued guidance for agencies to use in implementing IPIA and IPERA.⁷

In light of the magnitude of the Medicaid program and its related improper payments, you raised questions about CMS's improper payment estimation methodology and related corrective action plans. The objectives of our review were to determine the extent to which (1) CMS's methodology for estimating Medicaid improper payments follows OMB guidance and produces reasonable national and state-level estimates and (2) corrective action plans have been developed to reduce Medicaid payment error rates and whether these plans addressed the types of errors identified.

To address these objectives, we reviewed applicable improper payment legislation and related OMB guidance, internal control standards, and financial reporting standards. We also reviewed CMS regulations on Payment Error Rate Measurement (PERM), CMS's internal written guidance, and results from state PERM reviews used for fiscal year 2011 reporting. In addition, we reviewed improper payment information reported in HHS's fiscal year 2011 AFR.

To further address the first objective, we compared CMS's sampling and statistical methods used to estimate the fiscal year 2011 Medicaid payment error rate with related OMB guidance. We focused on the Medicaid payment error rate reported for fiscal year 2011. As part of this assessment, we conducted interviews with CMS officials and its contractors to clarify our understanding of both the sampling and estimation methodologies. We also reviewed CMS's program manuals for both the payment error and eligibility payment error components of PERM, as well as professional statistical literature, to assess the

⁷OMB, Memorandum M-11-16, *Issuance of Revised Parts I and II to Appendix C of OMB Circular A-123* (Apr. 14, 2011). For programs administered at the state level like Medicaid, this OMB guidance allows for state-level estimates to be used to generate a national improper payment dollar estimate and rate. However, agencies are to submit plans to OMB for approval to provide national-level estimates for state-administered programs based on a systematic selection of such programs each year. The justification to use this type of approach must include a description of the states to be selected each year, the methodology for generating annual national estimates, and a justification for using the proposed plan rather than an estimate based on a random statistical sample.

statistical validity of CMS's methodology. In addition, we reviewed state-level payment error rates to determine whether the sample sizes assigned to states were in accordance with OMB statistical guidance. We also used the results of these reviews and analyses to identify and assess the reasons for any weaknesses in the estimation methodology, and their potential effects on identifying and reporting Medicaid improper payment estimates for fiscal year 2011 and going forward. In addition to reviewing the statistical methodology, we obtained actual payment error data for selected states and independently calculated the payment error rates. The scope of our review did not include an assessment of individual states' processes or payment systems. We assessed the reliability of the claims and error rate data by gaining an understanding of the processes the contractors or states use to perform reviews, including any use of data sharing to determine eligibility, and their quality controls. We determined that the data were sufficiently reliable for our purposes.

To further address the second objective, we reviewed agency policies and procedures related to the development of PERM corrective action plans (CAP) and CAPs for all 50 states and the District of Columbia used to address the root causes of improper payments identified from the PERM reviews, and conducted interviews with officials from CMS. We also reviewed CMS's error rate reduction plans and initiatives to reduce Medicaid improper payments. In addition, we assessed CMS's process for monitoring state corrective actions and its methodology for measuring the effectiveness of corrective actions to reduce improper payments against *Standards for Internal Control in the Federal Government* related to monitoring.⁸ The scope of our review did not include an assessment of individual states' implementation of their CAPs.

To support both objectives, we conducted site visits at seven state Medicaid offices (California, Florida, Illinois, Michigan, Pennsylvania, South Carolina, and Texas). During these site visits, we interviewed state personnel involved in the PERM process to gain an understanding of how these states compiled the universes of claims and beneficiaries that are sampled for the PERM reviews, how these states conducted eligibility reviews, and how these states developed corrective action plans and worked with CMS on corrective actions. We selected these states based

⁸GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

on criteria such as states' federal share of Medicaid payments and errors identified in PERM reviews. The seven states we visited collectively claimed about 37 percent of the total federal share of Medicaid payments made in fiscal year 2010.⁹ We also selected these states to achieve variation in the error rates found during PERM reviews included in the fiscal year 2011 reporting of the Medicaid improper payment estimate. One state had the highest error rate for eligibility reviews as well as the highest combined error rate. This selection also allowed us to focus on certain states with noted vulnerabilities in program integrity efforts, as well as states with possible best practices. Although it does not allow us to generalize findings to all states and thus the program as a whole, we believe these state visits, combined with our analysis of CAPs for all states, enable us to determine if states' corrective actions are addressing the types of improper payment errors that have been identified.

We conducted this performance audit from February 2012 to March 2013 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. See appendix I for additional details on our scope and methodology.

⁹The fiscal year 2010 data were the most recent data available at the time of our review for site visit selection.

Background

CMS's Process for Estimating Medicaid Improper Payments under PERM

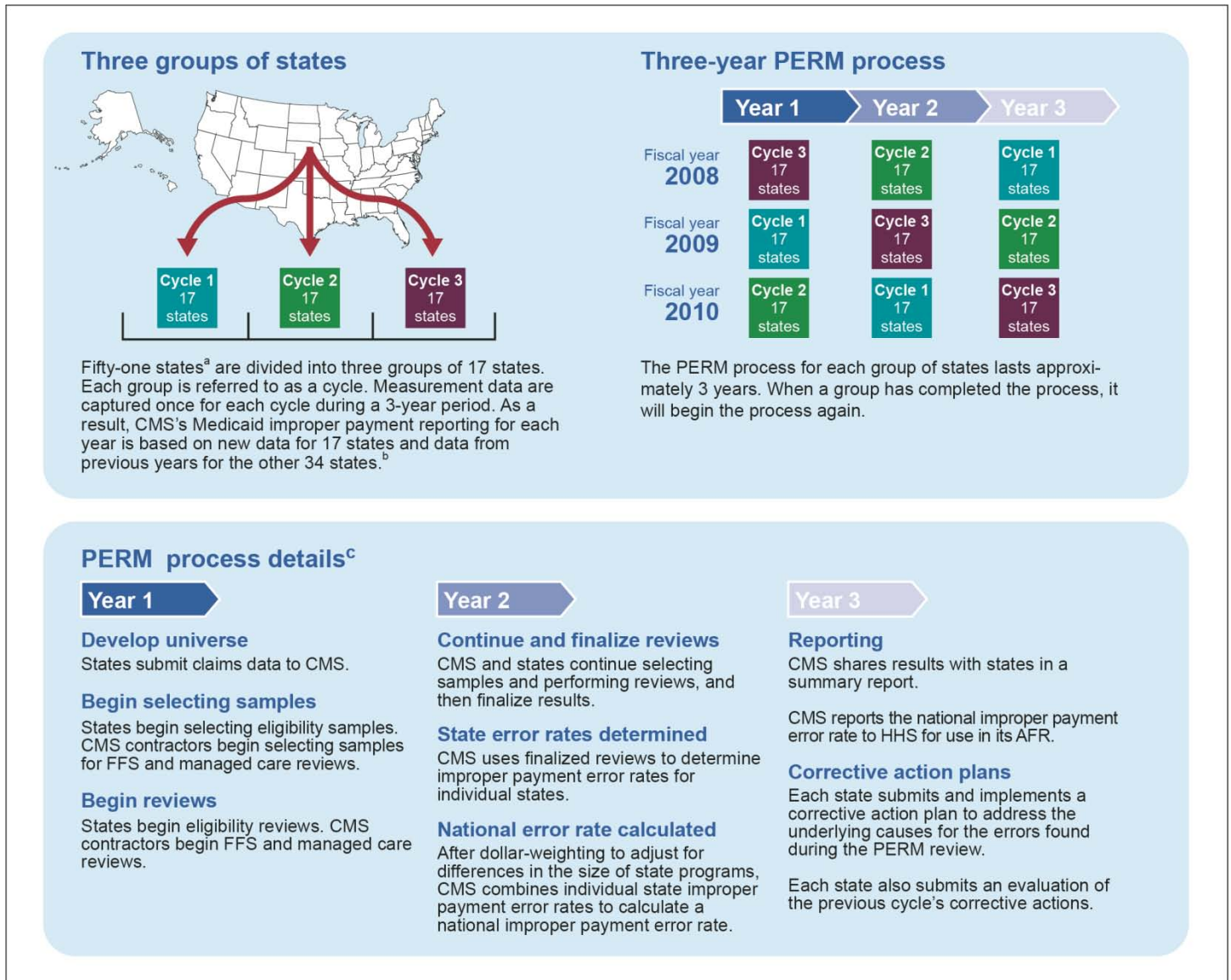
The purpose of the CMS PERM program is to produce a national-level improper payment error rate for Medicaid.¹⁰ CMS developed PERM in order to comply with the requirements of IPIA, which was amended by IPERA.¹¹ PERM uses a 17-state, 3-year rotation for measuring Medicaid improper payments. Medicaid improper payments are estimated on a federal fiscal year basis through the PERM process. The estimate measures three component error rates: (1) fee-for-service (FFS), (2) managed care, and (3) eligibility. FFS is a traditional method of paying for medical services under which providers are paid for each service rendered. Each selected FFS claim is subjected to a data processing review. The majority of FFS claims also undergo a medical review. Managed care is a system where the state contracts with health plans to deliver health services through a specified network of doctors and hospitals. Managed care claims are subject only to a data processing review. Eligibility refers to meeting the state's categorical and financial criteria for receipt of benefits under the Medicaid program. States perform their own eligibility reviews according to state and federal eligibility criteria. See appendix II for additional details on these three components. CMS uses its PERM Manual to provide detailed guidance for implementing CMS regulations on PERM. PERM regulations set forth the methodology for states to estimate Medicaid improper payments and outline the requirements for state CAPs.¹² Figure 1 shows the PERM process for estimating and reducing Medicaid improper payments.

¹⁰PERM is also used to produce a national-level improper payment error rate for the Children's Health Insurance Program.

¹¹CMS operated pilot projects—Payment Accuracy Measurement and PERM—in fiscal years 2002 through 2005, published interim final rules in 2005 and 2006, and implemented PERM in a final rule published on August 31, 2007.

¹²42 C.F.R. part 431, subpart Q.

Figure 1: PERM Process for Estimating and Reducing Medicaid Improper Payments for Fiscal Year 2011 Reporting



Source: GAO analysis of CMS's PERM process for estimating and reducing Medicaid improper payments as outlined in its PERM manual.

^aThe "51 states" refers to the 50 states and the District of Columbia.

^bFor example, fiscal year 2011 reporting is based on the measurement cycles for fiscal years 2008 to 2010, while fiscal year 2010 reporting is based on the measurement cycles for fiscal years 2007 to 2009.

^cBased on our analysis of CMS's PERM process, it is possible that there may be circumstances under which certain activities from years 1 and 2 might be delayed until years 2 and 3, respectively.

Through its use of federal contractors, CMS measures the FFS and managed care components while states perform the eligibility component measurement.¹³ CMS contracts with two vendors—a statistical contractor and a review contractor—to conduct the FFS and managed care review components of PERM and calculate error rates. The statistical contractor is responsible for (1) collecting and sampling claims and payment data for review, including performing procedures to ensure that the universe is accurate and complete; (2) reviewing state eligibility sampling plans; and (3) calculating state and national error rates. The review contractor is responsible for conducting data processing and medical reviews after the statistical contractor selects the samples of claims. Beginning with the fiscal year 2011 measurement cycle, state-specific sample sizes are calculated based on the prior measurement cycle’s component-level error rates and precision.

All payment error rate calculations for the Medicaid program (the FFS component, managed care component, eligibility component, and overall Medicaid error rate) are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. The overall Medicaid error rate represents the combination of FFS, managed care, and eligibility error rates. Individual state error rate components and state overall Medicaid error rates are combined to calculate the national component error rates and national overall Medicaid error rate. PERM accounts for the overlap between claims and eligibility reviews by calculating a small correction factor to ensure that Medicaid eligibility errors do not get “double counted” if the sampled item was also tested in either the FFS or managed care components. National component error rates and the national overall Medicaid program error rate are weighted by state size in terms of outlays, so that a state with a \$10 billion Medicaid program “counts” 10 times more toward the national rate than a state with a \$1 billion Medicaid program.

For fiscal year 2011 reporting—the reporting period covered by our audit—CMS reported an estimated national Medicaid improper payment error rate of 8.1 percent or \$21.9 billion (\$21,448 million in overpayments

¹³The Division of Error Rate Measurement (DERM) within CMS’s Office of Financial Management is responsible for implementing PERM. DERM is also responsible for implementing the Comprehensive Error Rate Testing process to estimate improper payments in the Medicare FFS program.

and \$453 million in underpayments).¹⁴ The weighted national component error rates are as follows: for Medicaid FFS, 2.7 percent; for Medicaid managed care, 0.3 percent; and for Medicaid eligibility, 6.1 percent.¹⁵ See appendix III for the state and national error rates for HHS's fiscal year 2011 reporting of Medicaid improper payments. See appendix IV for the national Medicaid outlays and the estimated improper payment error rate reported in HHS's AFRs for fiscal years 2007 to 2011.¹⁶

On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was enacted.¹⁷ As required under Section 601 of CHIPRA, HHS published a final rule on August 11, 2010, effective September 30, 2010, which requires that PERM eligibility reviews be consistent with the state's eligibility verification policy rather than reviewing eligibility against a single, federal methodology, which was done in the past. After publication of the final rule, states were allowed to review cases under the new methodology. Figure 2 shows the roll up of the error rate reported for fiscal year 2011.

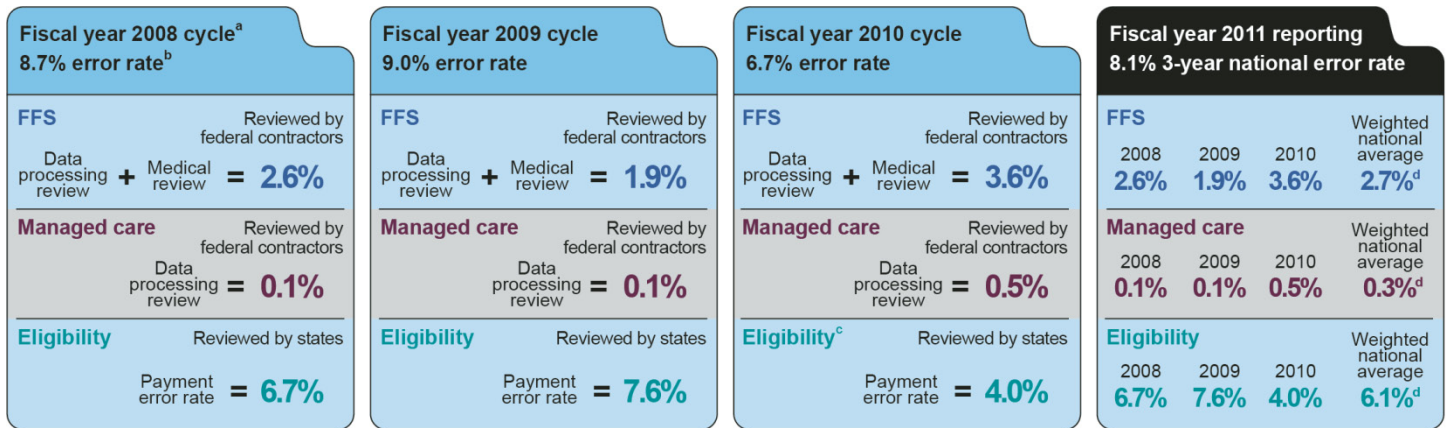
¹⁴According to CMS, the estimated error rate of 8.1 percent for fiscal year 2011 has a margin of error at the 90 percent confidence level of no more than plus or minus 2.2 percentage points. Also, this breakdown of overpayments and underpayments was not reported in fiscal year 2010 or previous years.

¹⁵The weighted national component error rates do not total the national Medicaid improper payment error rate because the combined rate is a weighted average of FFS and managed care error rates, with the addition of the eligibility error rate. Also, a small correction factor ensures that Medicaid eligibility errors do not get "double counted" if the sampled item was also tested in either the FFS or managed care component. According to CMS, at the 90 percent confidence level, the estimated FFS error rate of 2.7 percent has a margin of error of no more than plus or minus 0.6 percentage points; the estimated managed care error rate of 0.3 percent has a margin of error of no more than plus or minus 0.1 percentage points; and the eligibility error rate of 6.1 percent has a margin of error of no more than plus or minus 2.2 percentage points.

¹⁶Fiscal year 2007 was the first year that HHS reported the results of PERM reviews for estimating the Medicaid improper payment error rate.

¹⁷Pub. L. No. 111-3, 123 Stat. 8 (Feb. 4, 2009).

Figure 2: Medicaid Error Rate Calculation for Fiscal Year 2011 Reporting



Source: GAO analysis of CMS's PERM methodology and support for fiscal year 2011 error rate reporting.

Note: All of the numbers shown in this figure are estimated from PERM sample data. Please see table 4 in app. V for the associated margins of error at the 90 percent confidence levels.

^aEach measurement cycle includes 17 states.

^bThe combined rate is a weighted average of FFS and managed care, with the addition of eligibility. A small correction factor ensures that Medicaid eligibility errors do not get "double counted" if the sampled item was also tested in either the FFS or managed care components.

^cEffective September 30, 2010, CMS required eligibility reviews to be consistent with the state's eligibility verification policy rather than reviewing eligibility against a single, federal methodology, which was done in the past.

^dThe weighted national average is weighted by expenditures and therefore may not average across for 2008, 2009, and 2010.

PERM Corrective Action Process

IPIA, as amended, requires the heads of federal agencies to report on the actions the agency is taking to reduce improper payments, including a description of the causes of improper payments identified, actions planned or taken to correct those causes, and the planned or actual completion date of the actions taken to address those causes. This law also requires heads of federal agencies to report on a description of the steps the agency has taken to ensure that agency managers, programs, and, where appropriate, states and localities are held accountable through annual appraisal criteria for (1) meeting applicable improper payment reduction targets and (2) establishing and maintaining sufficient internal controls, including an appropriate control environment that effectively prevents improper payments from being made and promptly detects and recovers improper payments that are made. According to OMB's implementing guidance for IPERA, agencies should utilize the results of their statistical sampling measurements to identify the root causes of improper payments and implement corrective actions to

prevent and reduce improper payments associated with these root causes.¹⁸ Agencies should continuously use their improper payment measurement results to identify new and innovative corrective actions to prevent and reduce improper payments. Agencies should also annually review their existing corrective actions to determine if any existing action can be intensified or expanded, resulting in a high-impact, high return on investment in terms of reduced or prevented improper payments.

While CMS has responsibility for interpreting and implementing the federal Medicaid statute and ensuring that federal funds are appropriately spent—including estimating improper payments—the program is administered at the state level with significant state financing. Consequently, CMS relies primarily on states to develop and implement CAPs to address reported PERM errors. Following each measurement cycle, the states included in the measurement are required to complete and submit a CAP based on the errors found during the PERM process. In addition to guidance in the PERM Manual, CMS provides guidance to states on the CAP process upon releasing the PERM error rates and throughout CAP development.

Estimate of National Medicaid Improper Payments Did Not Consider Revised Individual State Error Rates

CMS's PERM methodology for reporting a national Medicaid program improper payment estimate is statistically sound and meets OMB requirements. However, the process for accumulating the data used in deriving the reported national estimate does not consider the extent of any significant changes in state-level improper payment data that occurred after the initial year-end cutoff for state reporting. The impact of any such significant changes in states' PERM reviews that were not concluded by the annual measurement cycle cutoff dates could significantly affect the calculation of the rolling 3-year average national Medicaid error rate reported each year.

¹⁸OMB Memorandum M-11-16.

Design of CMS's PERM Methodology Meets Established OMB Requirements

The design of CMS's PERM methodology meets OMB requirements. CMS has documented the steps it took to design the sample and the steps taken to construct the sampling frame for the FFS, managed care, and eligibility review samples in its PERM Manual.¹⁹ The documentation also includes CMS's process for ensuring that each sampling frame was accurate, timely, and complete. For error rate measurement for the FFS and managed care components, as outlined in the PERM Manual, CMS uses a stratified random sample selected quarterly within each state to provide cases for the data processing and medical review testing. For the eligibility component, as outlined in CMS's PERM Manual, states use a simple random sample of eligible cases and negative cases, which are drawn each month during the measurement cycle.²⁰

Absent an alternate methodology specifically approved by OMB, agencies must obtain a statistically valid estimate of the annual amount of improper payments in programs and activities for those programs that are identified as susceptible to significant improper payments. The estimates are to be based on the equivalent of a statistically random sample of sufficient size to yield an estimate with a 90 percent confidence interval of not more than plus or minus 2.5 percentage points around the estimate of the percentage of improper payments. CMS reports national Medicaid error rates at this 90 percent confidence interval to be consistent with OMB's requirements, but CMS's procedures provide that the sample size for PERM is to conform to OMB optional guidance for estimating payment errors—specifically, the PERM Manual specifies a target precision of plus or minus 3 percentage points at a 95 percent level of confidence within each state.²¹ The PERM Manual provides for the sample size for each state to be based upon the previous payment error rate and the OMB optional standard for the precision and confidence level. To estimate the

¹⁹A sampling frame is a list or set of procedures for identifying all elements of a target population.

²⁰Negative cases are cases where eligibility was denied or terminated. They are discussed in more detail later in this report.

²¹The optional OMB standard of a 3 percentage point precision at the 95 percent level of confidence is more rigorous in terms of the required sample size for the states than the regular OMB standard of a 2.5 percentage point precision at the 90 percent level of confidence. An increased sample size achieves greater precision in the estimate at the state level. However, according to CMS, the estimated error rates included in fiscal year 2011 reporting at the national level have margins of error at the 90 percent confidence level of no more than plus or minus 2.5 percentage points.

percentage of dollars paid in error, CMS's PERM Manual provides for using a ratio estimation methodology to produce the PERM estimate. This means the PERM payment error rate is a ratio of the estimated total dollars paid in error divided by the estimated total payments. The choice of ratio estimation methodology under these circumstances is statistically appropriate.

The PERM Manual describes the data collection methods for the medical reviews, data processing reviews, and eligibility determinations. The PERM Manual also describes the statistical ratio estimation methodology to be used to produce the estimated percentage of dollars paid in error. CMS's PERM Manual also provides for the error rates and summary reports to be provided to each state participating in the measurement cycle. We found that CMS's PERM Manual is consistent with OMB statistical guidance.

Procedures Used in National Error Rate Calculation Did Not Consider Updates to State-Level Rates

Although the CMS PERM methodology is statistically sound, CMS did not have procedures for considering the impact of any revisions to state-level error rates in calculating the national error rate after the cutoff date for each of the 3 measurement years. Specifically, the individual state error rates used to calculate the national error rate are not updated to reflect activities occurring after the PERM cycle cutoff. Without a process to consider these more current data on states' reported improper payment error rates, the reliability of CMS's reported national estimate may be adversely affected. OMB has identified as a best practice that agencies should establish a policy for handling unscheduled corrections to data, such as including threshold criteria identifying conditions under which data will be corrected and redisseminated.²²

According to the PERM Manual, a state may request a new error rate calculation from CMS after the cycle cutoff date for informational purposes and for determining sample sizes for the next cycle under

²²OMB, *Standards and Guidelines for Statistical Surveys* (September 2006). Although this guidance is not incorporated into OMB's improper payment estimation guidance, we cite it as a best practice because it describes techniques that can make government statistical sampling and reporting more accurate and reliable.

certain circumstances.²³ For example, states may request a recalculation when information supporting a claim as correctly paid was submitted to CMS after the cycle cutoff date—but CMS’s review contractor did not have time to complete the review—or when a mistake made by the PERM contractor was identified. This request must be made within 60 business days of the posting date of the state’s program error rate on the CMS review contractor’s website. In such instances, CMS will issue a revised rate to the state. However, each state’s official error rate—used in the calculation of the national Medicaid error rate—will not change as a result of this recalculation. According to CMS, official error rates will be calculated based on information received by the cycle cutoff date. While CMS aims for a cycle cutoff date of July 15—4 months prior to the reporting date—the CMS cycle manager may extend the cycle cutoff date depending on the progress of the PERM reviews.²⁴ CMS officials acknowledged that historically CMS has had to postpone the cycle cutoff to allow the process to be as complete as possible while still permitting CMS to report an improper payment rate timely in HHS’s AFR. However, after the cutoff date, CMS’s PERM Manual does not allow for any revisions to be factored into a state’s official error rate.

In reviewing the results of state PERM reviews, we identified some instances where CMS issued revised state Medicaid error rates. For example, CMS issued a revised rate to one state for its eligibility reviews for the fiscal year 2008 measurement cycle because in January 2010, two months after error rate reporting, CMS and the state discovered that the amount of dollars in error was reported incorrectly by the state. This revised overall state error rate estimate decreased from 20.8 percent to 7.8 percent.²⁵ In another example for the same fiscal year 2008 measurement cycle, in December 2009, 1 month after error rate reporting, CMS issued a post-cutoff date revised rate to a state for its FFS reviews because CMS received additional documentation from providers

²³State-level sample sizes went into effect for fiscal year 2012 reporting (i.e., starting with the fiscal year 2011 PERM measurement cycle). Beginning in the fiscal year 2011 PERM measurement cycle, individual state sample sizes are calculated based on that state’s prior year’s error rates for each of the three PERM components. Any revised error rates will be used for this purpose.

²⁴According to CMS officials, a cutoff date is needed to ensure that CMS has sufficient time to calculate and report the national Medicaid error rate.

²⁵According to CMS, this estimate has a margin of error at the 95 percent confidence level of no more than plus or minus 4.9 percentage points.

after the cycle cutoff date for official error rate calculations. This revised overall state error rate estimate decreased from 6.4 percent to 5.9 percent.²⁶ These revised percentages were not included in the official error rates used to calculate the national estimate of Medicaid improper payments. While these were both smaller states and the actual impact on the national error rate would be minimal, CMS's PERM Manual does not provide for CMS to consider the impact and it is possible that these types of changes would have had an impact on the national error rate reported in the subsequent 2 years if the changes were significant and were for states with larger levels of outlays.

Because the national error rate is based on 3 years of data and corrections to the 2 years of older data after the cutoff date are not officially recognized by CMS, the entire 3-year cycle could be affected. As a result, the reported estimate of Medicaid improper payments may be adversely affected if needed corrections are significant. This potentially affects CMS's ability to accurately report on the extent of improper payments, evaluate program performance, and utilize its own resources, as well as state resources, effectively to identify and reduce improper payments.

Deficiencies in CMS's Guidance and Monitoring Impair Efficient and Effective Medicaid Program Improper Payments Reductions

CMS and state agencies developed CAPs that were generally responsive to identified payment errors. However, CMS's PERM Manual does not provide for addressing all nonpayment errors either by identifying specific corrective actions or by analyzing these errors to determine whether actions, if cost effective, are needed. Also, CMS's PERM Manual does not identify conditions under which corrective action for an error should not be undertaken because the cost of state corrective actions would outweigh the benefit. In addition, not all required elements of the CAPs are being completed by all states and CMS's written guidance on these required elements is not clear or consistent. Further, CMS's internal guidance on monitoring state CAPs is not sufficient to help ensure that states' CAPs contain all of the required elements and that states prevent and reduce improper payments going forward.

²⁶According to CMS, this estimate has a margin of error at the 95 percent confidence level of no more than plus or minus 4.7 percentage points.

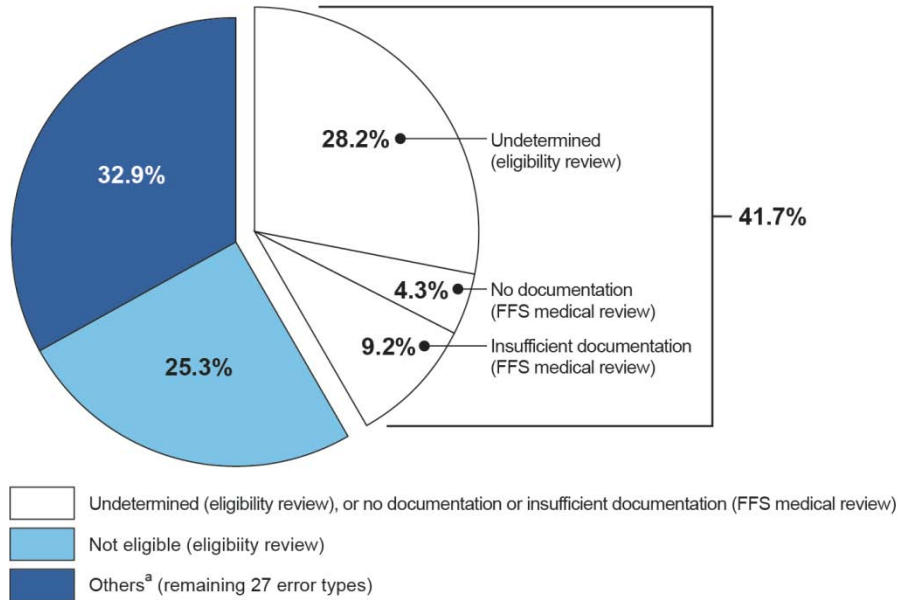
**Corrective Action Plans
Developed and Responsive
to Identified PERM
Payment Errors**

States are responsible for developing, executing, and evaluating CAPs to address specific errors identified during the PERM reviews, and CMS has reported on other initiatives to supplement state corrective actions and help reduce errors. We found that state CAPs were generally responsive to the types of payment errors identified in the PERM reviews.

Through PERM, CMS identifies and classifies types of errors and shares this information with each state. States are then to analyze and determine the root causes for their specific improper payments. According to CMS, in addition to the PERM Manual, it provides guidance to state contacts on the CAP process upon providing the PERM error rates and throughout the CAP development.

As reported by CMS, and shown in figure 3, overall, the majority of the errors reported in fiscal year 2011 (about 54 percent) for the Medicaid program—based on the fiscal years 2008 to 2010 measurement cycles—were a result of cases reviewed for eligibility, where recipients were either not eligible (25.3 percent) or where their eligibility status could not be determined (28.2 percent). The most common causes of cases in error for the FFS medical review was insufficient documentation (9.2 percent) or no documentation (4.3 percent). Our analysis of error types is shown in appendix VI.

Figure 3: Types of Errors Identified in the Fiscal Years 2008 to 2010 PERM Measurement Cycles Based on Number of Errors



Source: GAO analysis of CMS error data.

Note: Values do not total 100 percent because of rounding.

^aThe other 27 error types included instances where the incorrect number of units was billed, the state overpaid an amount of expenses, an individual was eligible for the Medicaid program but not a particular service, and payment did not correspond with the applicable pricing schedule.

As shown in figure 3, almost 42 percent of reported PERM review errors resulted from documentation deficiencies, including either a lack of or insufficient documentation, or because a definitive review decision could not be made because of a lack of or insufficient documentation (undetermined). As these are common types of errors, CMS has reported on certain corrective actions that states have developed to address them. Specifically:

- No documentation and insufficient documentation. In about 14 percent of all PERM errors, reviewers identified errors because either the provider did not respond to the request for records within the required time frame (no documentation—4.3 percent) or there was not enough documentation to support the service (insufficient documentation—9.2

percent).²⁷ According to CMS, because much of the error rate in the past was due to missing or insufficient documentation, the majority of states focused on provider education and communication methods to improve the providers' responsiveness and timeliness.

- Undetermined. In about 28 percent of all PERM errors over the 3-year period, reviewers were unable to determine whether or not a beneficiary was eligible for Medicaid because the case record lacked or contained insufficient documentation.²⁸ The PERM Manual outlines the due diligence a state must take before citing the case as "undetermined." According to CMS, specific corrective action strategies implemented by the states to reduce these types of eligibility errors have included leveraging technology and available databases to obtain eligibility verification information without client contact;²⁹ providing additional caseworker training, particularly in areas determined by the PERM review to be error prone; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the state-specific CAPs that are developed in response to the PERM findings, CMS has reported on other initiatives to lower error rates in HHS's fiscal year 2011 AFR. For example, to help address the insufficient documentation errors found in medical reviews, CMS reported that it increased its efforts to reach out to providers and to obtain medical records to help resolve this problem. CMS also reported that it gives

²⁷These errors may include claims that are valid but for which appropriate documentation was not received as of the cutoff date, and therefore these are considered errors.

²⁸During eligibility reviews, these cases were coded as "undetermined," meaning that the case record lacks or contains insufficient documentation, in accordance with the state's documented policies and procedures, to make a definitive review decision for eligibility or ineligibility. "Undetermined" errors may include cases of beneficiaries who are in fact eligible for Medicaid but their eligibility was not confirmed, and therefore these are considered errors.

²⁹We have previously reported that when effectively implemented, data sharing can be particularly useful in confirming initial or continuing eligibility of participants in benefit programs and in identifying any improper payments that have already been made. GAO, *Improper Payments: Remaining Challenges and Strategies for Governmentwide Reduction Efforts*, [GAO-12-573T](#) (Washington, D.C.: Mar. 28, 2012). In January 2013, the Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248, 126 Stat. 2390 (Jan. 10, 2013), was enacted, which, among other things, established a "Do Not Pay Initiative" to facilitate data sharing between federal agencies for payment-verification purposes.

states more information on the potential impact of these documentation errors and more time for the states to work with providers to resolve them. Table 1 outlines CMS’s reported overall strategies to reduce improper payments and strategies targeted at specific PERM error types.

Table 1: CMS’s Corrective Action Strategies to Reduce PERM-Identified Improper Payments

Corrective action focus	Corrective action strategy
Facilitate communication	<ul style="list-style-type: none"> • Best practice calls. CMS conducts national best practice conference calls to facilitate idea sharing and lessons learned among the states in order to decrease improper payments. • Provider open forum calls. CMS reported that it has sponsored a series of provider open forum calls for all states at the beginning of the PERM review cycle. • PERM website. CMS reported that it has enhanced the PERM website with up-to-date information and has included a separate web page for providers and an e-mail account for providers to communicate directly with CMS. • Post-CAP visits or webinars. CMS conducts post-CAP on-site visits or webinars with the states. The information covered during each meeting includes a recap of the previous PERM cycle, the disclosure of improper payment trends, the strategies for success in the upcoming PERM cycle, a review of previous CAPs submitted, a discussion of upcoming PERM initiatives, an overview of the various CMS work groups, and a summary of applicable Office of Inspector General audits.
Training and technical assistance	<ul style="list-style-type: none"> • Medicaid Integrity Institute. CMS’s Medicaid Integrity Institute is the first national Medicaid integrity training program and offers state officials training and opportunities to develop relationships with program integrity staff from other states. • Systems work group. CMS formed a state systems workgroup to address individual state system problems that may cause payment errors. The work group includes representatives from HHS and state staff. • Provider education webinars. CMS sponsors a series of PERM provider education webinars to educate providers on the PERM program and documentation submission requirements.
Improvements to PERM methodology	<ul style="list-style-type: none"> • PERM+. CMS developed PERM+, a new method for states to submit claims data for the PERM review. According to CMS, PERM+ makes claims data submission easier for states and condenses the PERM audit timeline. • Aggregate payments. CMS developed an aggregate payment methodology that, if appropriate, allows aggregate payments to be submitted and sampled for PERM, rather than at the beneficiary level.^a • Eligibility instructions. CMS reported that it is working with states to identify areas for clarification in the eligibility instructions to ensure an accurate measurement across the states.

Source: GAO analysis of CMS’s corrective action strategies.

^aWhile most Medicaid payments are made at the beneficiary level, states also calculate and pay for some services on behalf of a group of beneficiaries. This is known as an aggregate payment.

Although all states developed CAPs that were generally responsive to the payment errors identified through PERM reviews, we were unable to assess the CAPs’ impact on the improper payment error rate because of limited comparative data between PERM measurement cycle years.

Nonpayment Errors Not Addressed in All State CAPs

State CAPs did not always address errors identified during PERM reviews that did not have a payment error amount associated with them. Specifically, we identified three types of these nonpayment errors through our analysis of the PERM process that are not consistently addressed in all state CAPs—negative case errors, deficiencies, and technical errors.

- A *negative case error* occurs when a state incorrectly denies an application or terminates eligibility.
- A *deficiency* is generally defined as an action or inaction on the part of the state or the provider that could have resulted in a dollar error but did not.
- A *technical error* is an error where the eligibility caseworker did not act in accordance with state or federal policy, but this did not result in an erroneous eligibility determination or result in a difference between the amount that was paid and the amount that should have been paid.

CMS's PERM Manual requires that states test negative cases as part of their eligibility reviews. However, it does not clearly require that states address negative case errors in their CAPs. While a payment error rate is not calculated because there are no payments associated with negative cases, a negative case error rate is calculated to estimate the percentage of the decisions in which eligibility was incorrectly denied or terminated. Our analysis showed that for fiscal year 2011 reporting, approximately 40 percent of the states where negative case errors were identified did not address negative case errors in their CAPs. According to CMS officials, these negative errors should be included in state CAPs.

While deficiencies do not result in a dollar amount in error and therefore had no impact on the payment error rate for fiscal year 2011, they may represent issues that need to be addressed to prevent future payment errors. Although not considered payment errors, some deficiencies were noted during PERM data processing and medical reviews.³⁰ Examples of deficiencies identified in FFS and managed care reviews include the following:

³⁰Prior to the fiscal year 2010 measurement cycle, these were not coded as deficiencies but were classified as errors. Beginning with the fiscal year 2010 cycle, CMS documents the deficiencies in a state's final PERM cycle report for the state's consideration.

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- A data processing deficiency in which a male was coded as a female in the system but because the service provided could have been appropriate for either sex, it did not result in a dollar difference.
 - A medical deficiency wherein although a provider billed for the wrong procedure code, the correct procedure code would have paid the same rate per unit. Therefore, it did not result in a dollar difference but could have under other circumstances.

Our analysis showed that deficiencies identified in PERM reviews represented approximately 8 percent of the total FFS and managed care errors identified for the fiscal year 2011 reporting, and that approximately 67 percent of these deficiencies were not included or analyzed in state CAPs. In addition, only 10 of the 43 states with deficiencies addressed these deficiencies in their CAPs.³¹ While the PERM Manual does not clearly state that CAPs are to address deficiencies, CMS officials told us that states should address deficiencies in their CAPs.

During eligibility reviews, states may identify technical errors. An example of a technical error is a failure to follow state administrative procedures that do not affect eligibility if acceptable documentation is otherwise obtained that supports beneficiary eligibility. According to the PERM Manual, states are not currently required to report these technical errors to CMS and may document technical errors as appropriate during the PERM reviews.³² Furthermore, the PERM Manual suggests but does not require that states include an analysis of technical errors and related corrective actions in their CAPs.

Although these nonpayment errors did not result in improper payment amounts, they represent internal control deficiencies that could have prevented eligible beneficiaries from receiving Medicaid benefits or may result in improper payments in future years if not addressed. Not clearly requiring states to address nonpayment errors, or to document that sufficient analysis was performed to determine if corrective actions, if cost effective, are needed, may reduce the effectiveness of CAPs for addressing the underlying causes of improper payments. Further, this

³¹There were a total of 51 states measured for the fiscal years 2008 to 2010 time period, and 8 states did not have any deficiencies identified.

³²According to CMS officials, beginning with the fiscal year 2013 measurement cycle, states will be required to report technical errors to CMS.

may inhibit ongoing efforts to prevent and reduce improper payments and to ensure that Medicaid is provided to all eligible beneficiaries.

OMB's implementing guidance for IPERA requires agencies to implement corrective actions to prevent and reduce improper payments.³³ In addition, CMS's PERM regulations and its PERM Manual require each state to complete and submit a CAP based on errors found during the PERM process. However, while specifically allowing states to exclude eligibility technical errors, the PERM Manual does not clearly identify whether the states should consider or include deficiencies or negative case errors in their CAPs. While the PERM Manual does not clearly state that CAPs are to address both deficiencies and negative case errors, CMS officials told us that states should address both of these in their CAPs.

Requirements for State CAPs Do Not Provide for Considering Costs versus Benefits of Corrective Actions

Although CMS's PERM Manual requires each state to complete and submit a CAP based on the errors found during the PERM process, this guidance makes no exception for small errors—sometimes caused by rounding—which may result in states incurring costs to implement corrective actions that exceed the benefits of those actions. In its PERM Manual, CMS encourages states to use the most cost-effective corrective actions that can be implemented to best correct and address the root causes of the errors; however, it does not acknowledge that states can address errors by documenting situations where they determined that the costs of implementing the corrective action exceed the benefits.

Officials at one state we visited told us that the cost of implementing a system to correct some of its errors that were less than a dollar would outweigh the benefits of this action. A PERM review in this state identified 11 pricing errors resulting from incorrect rounding that netted to \$0.53.³⁴ State officials informed us that they were aware of this rounding issue, as it had been identified in the previous PERM cycle and CMS also identified and reported this type of error for the fiscal year 2011 measurement cycle. According to this state, the original estimate for a system solution to correct these rounding errors was \$575,000 to \$1,150,000. State

³³OMB Memorandum M-11-16.

³⁴Pricing errors accounted for 4 percent of all of the errors identified across states for the fiscal years 2008 to 2010 measurement cycles, and about 1 percent of all dollars in error.

officials told us they did not believe that the cost to address this issue was justified as the return on investment for the system solution to correct the condition might never be realized. According to CMS, in e-mail communication with this state, it told state officials that if the state determines that the cost of implementing a corrective action outweighs the benefits then the final decision of implementing the corrective action is the state's decision. The state continued to pursue corrective actions and was ultimately able to obtain a revised estimate of \$115,000 for changes to the system, based on further detailed analysis of the necessary solution. The state now plans to redesign its system in order to avoid these types of PERM errors going forward.

According to *Standards for Internal Control in the Federal Government*, management should design and implement internal controls—in this case, controls to prevent and reduce improper payments—based on the related costs and benefits. Further, PERM regulations require states to evaluate their corrective action plans by assessing, among other things, the efficiencies that they create. However, the lack of clear written guidance for states on how to address situations where the cost of corrective actions identified by states may outweigh the benefits because of the low dollar amounts associated with these types of errors may result in an unnecessary burden on state resources.

State CAPs Do Not Contain All Required Elements

Although we found that states have generally been engaged in the PERM CAP process and developed CAPs to address improper payment errors, not all required elements of the CAPs are being completed by all states. When developing CAPs, CMS's PERM regulations require states to perform five key steps to reduce improper payment errors identified through the PERM reviews. For CAPs subsequent to the initial measurement year, CMS's PERM regulations also require an update on the previous CAP. These requirements are summarized in figure 4.

Figure 4: CMS’s Regulatory Requirements for States to Develop CAPs to Reduce Improper Payments

State CAPs - required steps	
1. Conduct data analysis	States must conduct data analysis, such as reviewing clusters of errors, general error causes, characteristics, and frequency of errors that are associated with improper payments.
2. Identify programmatic and root causes of errors	States must review the findings of the data analysis to determine the specific programmatic causes to which errors are attributed (for example, provider lack of understanding of the requirement to provide documentation) and to identify root error causes.
3. Corrective action planning	States must determine the corrective actions to be implemented that address the root error causes.
4. Implement and monitor plan	States must develop an implementation schedule for each corrective action initiative and implement those actions in accordance with the schedule. The schedule must identify a timeline for each action, including target implementation dates, milestones, and monitoring.
5. Evaluate plan	States must evaluate the effectiveness of the corrective action by assessing improvements in operations, efficiencies, number of errors, and improper payments.
Subsequent state CAPs	
1.	States must submit to CMS a new CAP for each subsequent error rate measurement that contains an update on the status of a previous CAP. The update should address the effectiveness of implemented corrective actions, findings on short-term corrective actions, and the status of the long-term corrective actions.
2.	States should also address discontinued or ineffective actions, actions not implemented, and those actions, if any, that were substituted for such discontinued, ineffective, or abandoned actions.

Source: 42 C.F.R. § 431.992.

Not all required elements of the CAPs—such as the evaluation step or the update on the previous CAP—were consistently reported on by all states.

- For example, for fiscal year 2011 reporting, 8 of the 51 states did not submit the required evaluation element of the CAP. An additional 9 states submitted the evaluation element for some, but not all PERM components.
- Furthermore, for fiscal year 2011 reporting, only 24 of the 34 states required to submit an update of the previous CAP complied with this requirement. Another 5 states submitted updates for some, but not all, of the PERM components, and of the 29 states that submitted complete or partial updates of their previous CAPs, only 19 submitted

them by the due date required by CMS. The other 10 were submitted after CMS followed up with the states.

CMS officials acknowledged that some state CAPs are missing certain elements, and they are in the process of finalizing specific procedures to outline CMS's role in reviewing state CAPs and following up with states to obtain any missing elements, as discussed later in this report.

CMS's PERM Manual, updated in September 2011, provides guidance for state CAP development, but it does not include specific instructions for completing the evaluation element or on how to report the update on the previous CAP. Furthermore, the CAP template included in the PERM Manual does not include these two required elements. However, on its PERM website, CMS has provided a separate example of a CAP for the states to utilize that includes examples of the evaluation element and a separate report for the update on the previous CAP. Inconsistencies between the PERM Manual—which includes a CAP template—and the example CAP on the PERM website may cause confusion regarding what states are to include in their CAPs. As of August 2012, CMS had updated its PERM Manual and the CAP template to include instructions and a template for reporting on the update of the previous CAP. However, the updated template still did not include the evaluation element, and the separate example of a CAP on the PERM website was not updated to be consistent with the updated PERM Manual guidance and template. Clear, consistent written guidance and instructions on all required elements for CAPs would assist the states in submitting complete CAPs, and increase the likelihood that CMS has the information necessary for analyzing the progress and effectiveness of state CAPs. The lack of clear, consistent guidance in the PERM Manual and the related template on the PERM website on how to develop key elements of the state CAP may have contributed to the missing elements we describe in this report.

CMS's Monitoring of State CAPs Is Limited

CMS lacked a formal policy describing its role in monitoring state CAPs to ensure that (1) the CAPs contained all of the required elements and completely addressed errors identified in the PERM reviews and (2) states were making progress on implementing corrective actions.

In our high-risk series update, we reported that CMS needs to ensure that states develop appropriate corrective action processes to address

vulnerabilities to improper Medicaid payments.³⁵ Our analysis of state CAPs continues to identify issues regarding CMS's coordination with states in developing and implementing their CAPs. Specifically, during our review and analysis of state CAPs for the fiscal years 2008 to 2010 PERM measurement cycles, we found that CMS had not conducted sufficient oversight to ensure that states submitted complete CAPs, took the five required steps in developing CAPs, and updated the status of previous CAPs.

As discussed previously, not all required elements of the CAPs—such as the evaluation step or the update on the previous CAP—were being completed by all states. Once the CAPs are submitted, officials in the seven states we visited noted that there was minimal monitoring of implementation by CMS. For example, officials in one state told us that CMS did not follow-up with the state on the implementation of the corrective actions until the state submitted the CAP related to its next error rate measurement 3 years later. According to CMS officials, they do not track the progress of the states' implementation of CAPs and are not required to do so.³⁶ However, CMS officials told us that they review the implementation information that the states provide in their CAPs, specifically in the update of their previous CAPs, and hope to see a reduction in error rates as the CAPs are implemented. Additionally, based on our analysis of state CAPs for fiscal year 2011 reporting, we also noted that approximately 5 percent of all payment errors identified during the PERM reviews were not fully addressed by all states in their CAPs. Improved monitoring by CMS would help ensure that state CAPs contain all of the required elements and are addressing all types of errors identified through the PERM process, and that the actions identified are appropriate to reduce those types of errors going forward.

The responsibility for oversight of the states' development, implementation, and evaluation of their CAPs rests with the Division of Error Rate Measurement (DERM) within CMS's Office of Financial Management. These efforts include coordinating the CAP process with

³⁵[GAO-11-278](#).

³⁶While PERM regulations outline the elements that states are required to include in their CAPs, PERM regulations explicitly state that CAPs do not have to be approved by CMS.

the states and other agency offices. The Medicaid Integrity Group (MIG)³⁷ within CMS's Center for Program Integrity is responsible for reviewing the state CAPs, with assistance from the agency's regional offices. According to CMS, MIG reviews the state CAPs to (1) ensure the plans address the errors identified during the PERM reviews, (2) provide feedback to the states for improvements, and (3) review the implementation status of the state's previous CAP.

Oversight through continuous monitoring helps ensure that actions are taken to effectively work toward reducing improper payments. According to OMB's implementing guidance, agencies must ensure that their managers and accountable officers, program and program officials, and where applicable states and local partners are held accountable for reducing improper payments.³⁸ Therefore, although the states are responsible for developing, implementing, and monitoring their CAPs, CMS should be responsible for monitoring states' compliance with CMS's regulations related to the PERM process.

We also found that the roles and responsibilities of DERM and MIG are not formally outlined in policies and procedures for the PERM review and corrective action process. CMS officials told us that they are in the process of developing protocols to address the CAP review process. Specifically, CMS officials told us that they have developed a draft policy describing each party's role in the different stages of the PERM CAP process as well as a review guide to outline CMS's procedures for coordinating reviews of state CAPs. CMS plans to review state CAPs submitted in February 2013 using this new collaborative process for the first time for the states that are part of the fiscal year 2011 measurement cycle and were reported on in HHS's fiscal year 2012 AFR. According to CMS officials, they plan to review the CAPs to ensure that all of the attributes outlined in the PERM regulations are addressed and, as needed, notify the states of any missing elements. After reviewing the fiscal year 2011 cycle CAPs, CMS officials told us that they plan to further refine the standard operating procedures and CAP review guide before

³⁷The Deficit Reduction Act of 2005, Pub. L. No. 109-171, title VI, § 6034, 120 Stat. 4, 74 (Feb. 8, 2006), *codified, as amended*, at 42 U.S.C. § 1396u-6, established the Medicaid Integrity Program, which contracts for audit and educational services and provides long-term planning to combat fraud, waste, and abuse in Medicaid. To implement the Medicaid Integrity Program, CMS created MIG.

³⁸OMB Memorandum M-11-16.

the documents are finalized. CMS's draft policy and review guide were not finalized before the completion of our fieldwork, and we did not examine any interim drafts. Thus, we are unable to determine whether the planned revisions to existing procedures will fully address the deficiencies we identified concerning CMS's monitoring of state CAPs. Monitoring is CMS's opportunity to ensure that states are appropriately implementing the corrective actions that they have identified to help reduce improper payments. If states are not addressing all applicable issues or are not effectively implementing the actions outlined in their CAPs, future reductions in the Medicaid error rate may be limited. Additional monitoring by CMS would help hold the states accountable for developing, implementing, and evaluating corrective action strategies in support of CMS's efforts to prevent and reduce Medicaid improper payments.

Conclusions

The design of CMS's PERM methodology is statistically sound. However, refining the required PERM process for estimating and reporting national Medicaid improper payments so that the impact of corrections to the data after the cutoff date is considered would help ensure that the reported estimates are reasonably accurate and complete. As CMS reports its estimated Medicaid improper payments based on a rolling 3-year estimate, adjustments made to any of these 3 years can affect yearly reporting and potentially affect the accuracy of the reported national estimate. Given the importance of providing HHS management, OMB, and the Congress with accurate information on the extent of improper payments in federal programs, it is imperative that CMS ensure that its reported estimates of Medicaid improper payments are reliable.

Corrective actions are critical for preventing and reducing improper payments. While states have developed corrective action plans to address payment errors identified in PERM reviews, not all nonpayment errors were addressed in these plans, which could hinder the prevention of future improper payments. Also, while states are currently required to address all errors, clear written guidance that permits states to document why an action is not being implemented would help ensure the most efficient and effective use of state resources for errors that do not pose a risk of significantly affecting future improper payments. Further, ensuring that states have clear written guidance for developing corrective action plans is key to CMS's ability to oversee states' corrective action processes. Strengthening CMS's required procedures for monitoring the state-level corrective actions is critical to help ensure that states make progress in preventing and reducing improper payments.

Recommendations for Executive Action

In order to ensure the accuracy of reported improper payment estimates for the Medicaid program, we recommend that the Secretary of HHS direct the CMS Administrator to take the following action:

- Update PERM Medicaid improper payment reporting procedures to provide for considering any corrections to state-level improper payment error data subsequent to the cutoff date that would have a significant impact on any of the 3 years used to develop the rolling average for the reported national Medicaid improper payment estimate.

To help ensure that corrective action strategies effectively address identified types of improper payments and reduce Medicaid improper payments in a cost-effective manner, we recommend that the Secretary of HHS direct the CMS Administrator to take the following three actions:

- Revise the PERM Manual to provide that states (1) analyze all deficiencies, negative case errors, technical errors, and minimal dollar errors identified in PERM reviews to determine if any corrective actions, if cost effective, are needed to prevent such errors in the future and (2) document the results of their analysis.
- Clarify guidance in the PERM Manual, and on the PERM website, on the required elements to be included in a CAP and the specific actions states are to take each measurement cycle to (1) effectively prepare and evaluate their current cycle's CAPs and (2) provide updates to their previous cycle's CAPs.
- Finalize draft policies and procedures to clarify specific CMS officials' roles and responsibilities for monitoring states' corrective actions to ensure, at a minimum, that (1) the CAPs contain all of the required elements and completely address errors identified in the PERM reviews and (2) states are making progress on implementing corrective actions.

Agency Comments and Our Evaluation

We provided a draft of this report to the Secretary of HHS for comment. In its written comments, reprinted in appendix VII, HHS concurred with the four recommendations in our report. HHS cited a number of actions already taken and other initiatives planned or under way related to our recommendations. For example, with respect to our three recommendations to help ensure that corrective action strategies effectively address identified types of improper payments and reduce Medicaid improper payments in a cost-effective manner, HHS cited CMS's plans to update its PERM Manual and other relevant documents consistent with our recommended actions to clarify and standardize

guidance. HHS also cited action under way to finalize policies and procedures related to monitoring states' corrective actions.

HHS also concurred with our recommendation to update procedures for considering the impact of any corrections to state-level improper payment errors on reported national error rates. HHS stated that it will consider revising its procedures in this area. HHS also expressed concern that the draft suggests that past reported national Medicaid error rates were unreliable. We acknowledged in our draft report that the prior year post-cutoff date error rate revisions we reviewed were not sufficient to have had an impact on the national error rate for fiscal year 2011 reporting. Rather, our recommendation is focused on augmenting procedures to help ensure the reliability of future national error rate reporting. HHS also expressed concern about our suggestion that OMB's *Standards and Guidelines for Statistical Surveys* should be used to determine how to handle PERM-related data corrections. In our draft report, we characterized this as a best practice. HHS noted, and we agree, that OMB did not include guidance for handling unscheduled corrections to data in its implementing guidance for IPERA. However, taking action, as we recommended, to establish procedures to consider the extent to which any corrections to state-level improper payment data subsequent to the cutoff date would affect the reported national Medicaid improper payment estimate would best ensure the reliability of reported national error rates going forward. HHS also expressed concern about our suggestion that states may request a recalculation of the state-level error rate when records for a medical claim were received prior to the cycle cutoff date but CMS's review contractor did not have time to complete the review. HHS cited that CMS's review contractors will complete all reviews for claims where the documentation was received prior to the cycle cutoff date and that states may request a recalculation when information supporting a claim as correctly paid was submitted to CMS after the cycle cutoff date. We agreed with HHS's point and modified the report accordingly.

HHS also expressed concern about including the state error rates identified in appendix III of the draft. HHS commented that readers may use the rates to make state-to-state comparisons that are inappropriate because of variations in states' sizes and programs and in states' implementation and administration of their programs. We acknowledged HHS's concerns in our draft report by including language in appendix III to caution readers about using these state-level rates to make state-to-state comparisons. However, it is important to present these state-level error rates for transparency regarding the results of state PERM reviews.

In addition, HHS provided technical comments that we incorporated as appropriate and discussed in our additional evaluation in appendix VII.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-2623 or davisbh@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in appendix VIII.



Beryl H. Davis
Director
Financial Management and Assurance

Appendix I: Objectives, Scope, and Methodology

The objectives of this report were to determine the extent to which (1) the Centers for Medicare & Medicaid Services' (CMS) methodology for estimating Medicaid improper payments follows Office of Management and Budget (OMB) guidance and produces reasonable national and state-level estimates and (2) corrective action plans (CAP) have been developed to reduce Medicaid payment error rates and whether these plans addressed the types of payment errors identified.

To address these objectives, we reviewed the Improper Payments Information Act of 2002 (IPIA),¹ the Improper Payments Elimination and Recovery Act of 2010 (IPERA),² and related OMB guidance effective for fiscal year 2011.³ We also reviewed CMS regulations on Payment Error Rate Measurement (PERM)⁴ and CMS's internal written guidance on PERM. In addition, we reviewed results from state PERM reviews for fiscal years 2006 through 2011, prior GAO and Department of Health and Human Services (HHS) Office of Inspector General reports, and internal control standards. Further, we reviewed improper payment information reported in the Improper Payments Section of HHS's fiscal year 2011 agency financial report (AFR). We reviewed these documents to understand CMS's efforts to address IPIA and IPERA requirements and to identify previously reported issues with CMS's improper payment reporting.

To further determine the extent to which CMS's methodology for estimating Medicaid improper payments follows OMB guidance and produces reasonable national and state-level estimates, we compared the following components of CMS's methodology for estimating the fiscal year 2011 payment error rate with related OMB guidance: (1) sampling methods, including the sample size, sample selection, sample representation, and precision of the estimates, and (2) statistical methods

¹Pub. L. No. 107-300, 116 Stat. 2350 (Nov. 26, 2002), *codified, as amended, at 31 U.S.C. § 3321 note.*

²Pub. L. No. 111-204, 124 Stat. 2224 (July 22, 2010), *codified, as amended, at 31 U.S.C. § 3321 note.* Subsequent to the completion of our fieldwork, IPIA and IPERA were further amended in January 2013 by the Improper Payments Elimination and Recovery Improvement Act, Pub. L. No. 112-248, 126 Stat. 2390 (Jan. 10, 2013).

³OMB, Memorandum M-11-16, *Issuance of Revised Parts I and II to Appendix C of OMB Circular A-123* (Apr. 14, 2011).

⁴42 C.F.R. part 431, subpart Q.

used to estimate the error rates and precision. As part of this assessment, we did the following:

- Conducted interviews with CMS officials and its contractors to clarify our understanding of both the sampling and estimation methodologies.
- Reviewed the program manuals for both the payment error and eligibility payment error components of PERM to assess the statistical validity of CMS's methodology.
- Reviewed professional statistical literature to validate the suitability of stratified random sampling and ratio estimation to address the particular characteristics of the payment and eligibility data in the state-administered Medicaid program.
- Reviewed state-level payment error rates from the most recent year available to determine whether the sample sizes assigned to states met the precision level for payment error sampling in OMB statistical guidance.

We also used the results of these reviews and analyses to identify and assess the reasons for any weaknesses in the estimation methodology and their potential effects on identifying and reporting Medicaid improper payment estimates for fiscal year 2011 and going forward.

In addition to reviewing the statistical methodology, we obtained actual payment error data from CMS for the seven states selected for our site visits and independently calculated the payment error rates to confirm the calculations done by CMS using the statistical methodology specified in the program manuals. The basis for our site visit selection is discussed later in this appendix.

The scope of our review did not include an assessment of individual states' processes or payment systems. We assessed the reliability of the claims and error rate data by gaining an understanding of the processes the contractors or states use to perform their reviews, including any use of data sharing to determine eligibility, and their quality controls. We determined that the data were sufficiently reliable for our purposes.

To further determine the extent to which CAPs have been developed to reduce Medicaid payment error rates and whether these plans addressed the types of errors identified, we did the following:

- Reviewed agency policies and procedures related to the development of PERM CAPs and CAPs for all 50 states and the District of

Columbia, which are used to address the root causes of improper payments identified from the PERM reviews.

- Conducted interviews with officials from CMS related to its oversight role and its own initiatives for reducing Medicaid improper payments.
- Reviewed CMS's error rate reduction plans and initiatives to reduce Medicaid improper payments.
- Reviewed the reported causes of improper payments as outlined in HHS's fiscal year 2011 AFR.
- Assessed CMS's process for monitoring state corrective actions and its methodology for measuring the effectiveness of corrective actions to reduce improper payments.

As part of our review of states' CAPs, we assessed whether they

- addressed issues identified in fee-for-service, managed care, and eligibility reviews;
- included the required elements as outlined by CMS; and
- evaluated the effectiveness of implemented corrective actions.

The scope of our review did not include an assessment of individual states' implementation of their CAPs.

In addition, we conducted site visits at seven state Medicaid offices (California, Florida, Illinois, Michigan, Pennsylvania, South Carolina, and Texas). During these site visits, we interviewed state personnel involved in the PERM process to gain an understanding of how states compile the universes of claims and beneficiaries that are sampled for the PERM reviews, how eligibility reviews are conducted, and how the states develop corrective action plans and work with CMS on corrective actions. We selected these states based on criteria such as the states' federal share of Medicaid payments and errors identified in PERM reviews. The seven states we visited collectively claimed about 37 percent of the total federal share of Medicaid payments made in fiscal year 2010, the most recent data available at the time of our review for site visit selection. We also selected these states to achieve variation in the error rates found during PERM reviews included in the fiscal year 2011 reporting of the Medicaid improper payment estimate.⁵ One state had the highest error

⁵The Medicaid improper payment estimate reported for fiscal year 2011 included the results of the fiscal years 2008 to 2010 measurement cycles. CMS uses a 17-state 3-year rotation for measuring Medicaid improper payments, and therefore each state is reviewed once every 3 years.

rate for eligibility reviews as well as the highest combined error rate. This selection also allowed us to focus on certain states with noted vulnerabilities in program integrity efforts, as well as states with possible best practices. Although it does not allow us to generalize findings to all states and thus the program as a whole, we believe these state visits, combined with our analysis of CAPs for all states, enable us to determine if states' corrective actions are addressing the types of improper payment errors that have been identified.

We conducted this performance audit from February 2012 to March 2013 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 II: Fee-for-Service, Managed Care, and Eligibility Components of the Medicaid Error Rate Measurement

The Payment Error Rate Measurement (PERM) program uses a 17-state, 3-year rotation for measuring Medicaid improper payments. Medicaid improper payments are estimated on a federal fiscal year basis through the PERM process. The estimate measures three component error rates: (1) fee-for-service (FFS), (2) managed care, and (3) eligibility.

FFS and Managed Care Components

FFS is a traditional method of paying for medical services under which providers are paid for each service rendered. Managed care is a system where the state contracts with health plans to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered.

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS and managed care claims are drawn each quarter. Each selected FFS claim is subjected to a data processing review. The majority of FFS claims also undergo a medical review.¹ Managed care claims are subject only to a data processing review.²

- A data processing error is a payment error that can be determined from the information available from the claim or from other information available in the state Medicaid system, other related systems, as well as outside sources of provider verification (except medical reviews and eligibility reviews). Data processing errors include, but are not limited to, the following: payment for duplicate items, payment for noncovered services, payment for FFS claims for managed care services, payment for services that should have been paid by a third party but were inappropriately paid by Medicaid, pricing errors, logic edit errors, data entry errors, and managed care payment errors.
- A medical review error is an error that is determined from a review of the medical documentation in conjunction with state and federal medical policies and information presented on the claim. Medical

¹According to the Centers for Medicare & Medicaid Services, certain types of FFS claims do not go through this medical necessity review because of the nature of the claims. These types of claims include zero paid claims, fixed payments, Medicare premium payments, Medicare crossover claims, and denied claims.

²While the number of Medicaid beneficiaries enrolled in managed care has grown, and is expected to continue to expand, as of fiscal year 2010, the federal share of managed care claims represented about 24 percent of the total federal share of claims in dollars.

review errors include, but are not limited to, the following: lack of documentation, insufficient documentation, procedure coding errors, diagnosis coding errors, number of unit errors, medically unnecessary services, policy violations, and administrative errors.

Eligibility Component

Eligibility refers to meeting the state's categorical and financial criteria for receipt of benefits under the Medicaid program. States perform their own eligibility reviews according to state and federal eligibility criteria. An eligibility error occurs when a person is not eligible for the program or for a specific service and a payment for the service or a capitation payment covering the date of service has been made.³ An eligibility error can also occur when a beneficiary has paid the incorrect amount toward an assigned liability amount or cost of institutional care. The results from the eligibility reviews will include eligibility errors based on erroneous decisions as well as payment errors. The Centers for Medicare & Medicaid Services (CMS) combines the state-reported eligibility component payment error rates to develop a national eligibility error rate for Medicaid. This rate is calculated from the active case payment review findings.⁴ For fiscal year 2011 reporting, CMS estimated that the active case error rate was 8.2 percent while the weighted eligibility component error rate was 6.1 percent.

Eligibility reviews are also performed on a sample of negative cases.⁵ Negative cases contain information on a beneficiary who applied for benefits and was denied or whose program benefits were terminated based on the state agency's eligibility determination in the month that eligibility is reviewed. CMS calculates only a case error rate for negative cases, because no payments were made. The negative case error rate estimates the percentage of the decisions in which eligibility was incorrectly denied or terminated. For fiscal year 2011 reporting, CMS estimated that the negative case error rate was 4.9 percent. The results

³A capitation payment is a fixed payment, usually made on a monthly basis, for each beneficiary enrolled in a managed care plan or for each beneficiary eligible for a specific service or set of services.

⁴Active cases are those in which an individual or family is enrolled in Medicaid in the month of the sample.

⁵Negative cases are those that are denied or have a termination effective date in the month of the sample.

**Appendix II: Fee-for-Service, Managed Care,
and Eligibility Components of the Medicaid
Error Rate Measurement**

of all PERM reviews, including the negative case reviews, are used to determine future sample sizes.

Appendix III: State Error Rates for the Department of Health and Human Services' Fiscal Year 2011 Reporting of Medicaid Improper Payments

According to the Centers for Medicare & Medicaid Services (CMS), states' Medicaid improper payment error rates identified through the Payment Error Rate Measurement (PERM) program may vary because of multiple factors related to differences in how states implement and administer their programs and should be considered in the context of these differences and operational realities. CMS provides each state its specific error rate and data analysis reports to use to develop corrective actions designed to reduce major error causes and to identify trends in errors or other factors for purposes of reducing improper payments. Also, according to CMS, because of the variation of states' sizes, overall program variations, and different ways that each state's rate affects the national rate, CMS does not encourage comparisons based solely on error rates. PERM is designed to produce precise error rates at the national level. Therefore, according to CMS, sample sizes per state are relatively small and the precision of state-specific error rates varies significantly.

In addition, during the fiscal years 2008 and 2009 measurement cycles, CMS noted instances where some states' policies differed from CMS's policies for determining PERM errors. For example, according to CMS, in the review of some eligibility cases, policy and operational differences among states may have affected the degree to which states and providers could obtain documentation to validate payments and eligibility decisions for PERM purposes. According to CMS, states that have simplified eligibility documentation rules through use of self-declaration and administrative renewal often found it harder to obtain necessary documentation for PERM reviews, which were treated as errors for PERM. In its fiscal year 2011 agency financial report (AFR), the Department of Health and Human Services (HHS) reported that as required under Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009,¹ it published a final rule on August 11, 2010, effective September 30, 2010, which required the eligibility reviews to be consistent with the state's eligibility verification policy rather than reviewing eligibility against a single, federal methodology, which was done in the past. After publication of the final rule, states were allowed to review cases under the new methodology. HHS also reported that based on current regulations, certain cases from the fiscal years 2008 and 2009

¹Pub. L. No. 111-3, § 601, 123 Stat. 8, 96 (Feb. 4, 2009).

**Appendix III: State Error Rates for the
Department of Health and Human Services'
Fiscal Year 2011 Reporting of Medicaid
Improper Payments**

measurement cycles, included in the error rates below, would no longer be considered as errors.

Table 2 provides a list of state error rates used to determine HHS's fiscal year 2011 reporting of national Medicaid improper payments.

Table 2: State Error Rates Used to Determine HHS's Fiscal Year 2011 Reporting of National Medicaid Improper Payments

Measurement cycle ^a	State	Combined ^b		Fee-for-service (FFS)		Managed care		Eligibility	
		Error rate	Margin of error	Error rate	Margin of error	Error rate	Margin of error	Error rate	Margin of error
Fiscal year 2008	Alaska	0.6%	0.5%	0.5%	0.5%	0.0%	0.0%	0.1%	0.2%
	Arizona	2.6%	1.9%	2.7%	1.2%	0.0%	0.0%	2.2%	1.9%
	District of Columbia	20.1%	16.0%	6.2%	2.1%	0.2%	0.4%	16.0%	16.8%
	Florida	14.6%	13.0%	7.5%	2.1%	0.0%	0.0%	9.2%	13.7%
	Hawaii	16.8%	5.8%	5.7%	2.2%	0.0%	0.0%	13.4%	5.9%
	Indiana	17.2%	10.5%	4.4%	2.0%	0.0%	0.0%	14.3%	10.8%
	Iowa	4.9%	4.6%	1.7%	1.7%	0.0%	0.0%	3.3%	4.4%
	Louisiana	4.0%	3.1%	2.5%	2.9%	0.0%	0.0%	1.5%	1.1%
	Maine	5.7%	2.4%	3.8%	1.7%	0.0%	0.0%	2.0%	1.8%
	Mississippi	3.5%	3.2%	3.4%	3.1%	0.0%	0.0%	0.1%	0.3%
	Montana	4.4%	6.5%	0.9%	0.7%	0.0%	0.0%	3.6%	6.5%
	Nevada	7.3%	2.6%	4.9%	1.8%	0.1%	0.0%	3.3%	2.2%
	New York	7.8%	4.4%	1.5%	1.0%	0.0%	0.0%	6.7%	4.4%
	Oregon	20.8%	12.0%	1.7%	1.7%	0.0%	0.0%	20.0%	12.1%
	South Dakota	0.9%	0.7%	0.8%	0.7%	0.0%	0.0%	0.0%	0.1%
	Texas	5.1%	3.4%	0.4%	0.5%	0.4%	0.7%	4.7%	3.4%
Washington	6.4%	4.8%	3.5%	1.8%	0.9%	1.2%	3.6%	4.7%	
Fiscal year 2009	Arkansas	4.2%	2.0%	3.0%	1.3%	N/A	N/A	1.2%	1.6%
	Connecticut	3.3%	1.3%	1.5%	1.0%	0.1%	0.0%	2.0%	1.0%
	Delaware	5.0%	2.1%	3.5%	1.5%	0.4%	0.8%	2.8%	1.9%
	Idaho	1.6%	1.1%	1.2%	1.0%	0.0%	0.0%	0.4%	0.5%
	Illinois	3.8%	2.1%	1.5%	1.1%	0.0%	0.0%	2.3%	1.8%
	Kansas	10.4%	8.0%	1.1%	0.9%	0.0%	0.0%	9.6%	8.0%
	Michigan	69.9%	20.1%	1.7%	1.5%	0.0%	0.0%	69.6%	20.3%
	Minnesota	2.0%	1.5%	0.6%	0.5%	0.0%	0.0%	1.6%	1.4%
	Missouri	2.6%	1.2%	2.0%	1.2%	0.0%	0.0%	0.9%	0.8%
	New Mexico	1.9%	1.1%	3.8%	2.0%	0.0%	0.0%	0.4%	0.7%
	North Dakota	3.2%	2.4%	3.1%	2.4%	6.7%	3.4%	0.1%	0.1%
	Ohio	9.8%	11.5%	1.4%	1.2%	0.4%	0.7%	8.8%	11.6%

**Appendix III: State Error Rates for the
Department of Health and Human Services'
Fiscal Year 2011 Reporting of Medicaid
Improper Payments**

Measurement cycle ^a	State	Combined ^b		Fee-for-service (FFS)		Managed care		Eligibility	
		Error rate	Margin of error	Error rate	Margin of error	Error rate	Margin of error	Error rate	Margin of error
Fiscal year 2010	Oklahoma	1.2%	0.9%	1.2%	0.9%	N/A	N/A	0.0%	0.0%
	Pennsylvania	4.1%	3.6%	3.8%	4.2%	0.2%	0.4%	2.0%	2.8%
	Virginia	17.4%	11.8%	0.7%	0.6%	0.0%	0.0%	16.9%	11.9%
	Wisconsin	5.7%	7.7%	2.3%	1.6%	0.0%	0.0%	4.4%	7.8%
	Wyoming	8.3%	5.4%	2.8%	1.5%	N/A	N/A	5.7%	5.3%
	Alabama	2.4%	1.1%	1.5%	1.0%	2.1%	1.6%	0.8%	0.7%
	California	1.6%	0.9%	1.7%	1.0%	0.5%	1.0%	0.2%	0.3%
	Colorado	6.9%	2.5%	6.8%	2.1%	0.0%	0.0%	1.0%	1.7%
	Georgia	4.7%	2.7%	4.1%	1.9%	1.3%	1.5%	1.5%	2.4%
	Kentucky	2.0%	1.0%	2.3%	1.2%	0.4%	0.7%	0.0%	0.0%
	Maryland	3.2%	1.9%	1.8%	1.1%	0.2%	0.3%	2.0%	1.8%
	Massachusetts	13.4%	2.2%	17.7%	3.0%	1.0%	1.0%	0.0%	0.1%
	Nebraska	2.1%	1.1%	2.2%	1.1%	0.4%	0.7%	0.0%	0.0%
	New Hampshire	1.5%	1.1%	1.5%	1.1%	N/A	N/A	0.0%	0.0%
	New Jersey	2.6%	1.6%	2.0%	1.6%	0.0%	0.0%	1.0%	1.1%
	North Carolina	11.9%	15.3%	3.4%	2.5%	0.0%	0.0%	8.9%	15.7%
	Rhode Island	15.6%	5.8%	6.1%	2.1%	0.4%	0.8%	11.8%	5.9%
	South Carolina	18.8%	15.8%	2.6%	1.3%	0.0%	0.0%	17.2%	16.1%
	Tennessee	3.6%	4.6%	1.7%	2.9%	0.0%	0.0%	2.8%	4.5%
	Utah	8.2%	4.9%	4.5%	1.9%	0.0%	0.0%	4.5%	4.8%
Vermont	8.0%	2.7%	6.8%	2.4%	0.9%	1.2%	1.4%	1.4%	
West Virginia	32.7%	32.2%	4.2%	2.2%	0.0%	0.0%	30.2%	33.4%	

Source: CMS data on state improper payment error rates for the Medicaid program (unaudited).

Legend: N/A = not applicable (the state did not have a managed care component to measure during the related cycle).

Note: These rates reflect the states' official error rates used to calculate the national error rates and do not reflect any state error rates that were recalculated, upon a state's request, for informational purposes and to determine sample sizes for the next measurement cycle.

^aHHS reported the results of the fiscal years 2008 through 2010 measurement cycles in its fiscal year 2011 AFR.

^bThe combined rate is a weighted average of FFS and managed care, with the addition of eligibility. A small correction factor ensures that Medicaid eligibility errors do not get "double counted" if the sampled item was also tested in either the FFS or managed care components.

Appendix IV: Medicaid Outlays and Estimated Improper Payment Error Rates Reported by the Department of Health and Human Services

Table 3 provides a list of Medicaid outlays and estimated improper payment error rates reported in the Department of Health and Human Services' (HHS) agency financial reports (AFR).

Table 3: Medicaid Outlays and Estimated Improper Payment Error Rates Reported in HHS's AFRs

Dollars in millions

Fiscal year	Outlays	Fee-for-service (FFS) error rate	Managed care error rate	Eligibility error rate	Combined error rate ^a	Total estimated improper payments	Estimated overpayments ^b	Estimated underpayments ^b
2007 ^c	\$139,896	4.7%	N/A	N/A	4.7%	\$6,575	N/A	N/A
2008 ^d	\$177,547	8.9%	3.1%	2.9%	10.5%	\$18,642	N/A	N/A
2009	\$188,286	5.7%	1.5%	4.9%	9.6%	\$18,075	N/A	N/A
2010	\$239,012	4.4%	1.0%	5.9%	9.4% ^e	\$22,500	N/A	N/A
2011	\$269,241	2.7%	0.3%	6.1%	8.1% ^e	\$21,900	\$21,448	\$453

Source: HHS's AFR reporting, fiscal years 2007 to 2011, and Centers for Medicare & Medicaid Services' data on Payment Error Rate Measurement error rates (unaudited).

Legend: N/A = not applicable.

^aThe combined rate is a weighted average of FFS and managed care, with the addition of eligibility. A small correction factor ensures that Medicaid eligibility errors do not get "double counted" if the sampled item was also tested in either the FFS or managed care components.

^bThe breakdown of estimated overpayments and underpayments was not reported for fiscal years 2007 through 2010.

^cThis information for fiscal year 2007 reflects revised information reported in HHS's fiscal year 2008 AFR. Also, the combined error rate only represents the Medicaid FFS component as it was the only component measured during this cycle, and the review was limited to 17 states for the cycle.

^dFiscal year 2008 reporting was limited to 34 states.

^eHHS reported that as required under Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009, it published a final rule on August 11, 2010, which required the eligibility reviews to be consistent with the state's eligibility verification policy rather than reviewing eligibility against a single, federal methodology, which was done in the past. HHS also reported that based on current regulations, certain cases from the measurement cycles for fiscal years 2008 and 2009 would no longer be considered as errors.

Appendix V: Additional Details for Medicaid Error Rates

Table 4 provides the margins of error at the 90 percent confidence level for error rate data presented in figure 2.

Table 4: Margins of Error for Error Rate Data Presented in Figure 2

Measurement cycle or reporting year	Component	Error rate	Margin of error ^a
Fiscal year 2008 cycle	Combined ^b	8.7%	2.5%
	Fee-for-service (FFS)	2.6%	1.0%
	Managed care	0.1%	0.1%
	Eligibility	6.7%	2.4%
Fiscal year 2009 cycle	Combined ^b	9.0%	5.3%
	FFS	1.9%	0.6%
	Managed care	0.1%	0.1%
	Eligibility	7.6%	5.3%
Fiscal year 2010 cycle	Combined ^b	6.7%	3.0%
	FFS	3.6%	1.4%
	Managed care	0.5%	0.3%
	Eligibility	4.0%	2.9%
Fiscal year 2011 reporting (3-year national error rate)	Combined ^b	8.1%	2.2%
	FFS	2.7%	0.6%
	Managed care	0.3%	0.1%
	Eligibility	6.1%	2.2%

Source: GAO analysis of support for fiscal year 2011 error rate reporting.

^aAccording to the Centers for Medicare & Medicaid Services, the estimated error rates presented in this table have margins of error at the 90 percent confidence level of no more than plus or minus these percentage points.

^bThe combined rate is a weighted average of FFS and managed care, with the addition of eligibility. A small correction factor ensures that Medicaid eligibility errors do not get “double counted” if the sampled item was also tested in either the FFS or managed care components.

Appendix VI: Types of Errors Identified in Payment Error Rate Measurement Reviews

Table 5 provides a list of error types identified during the fiscal years 2008 to 2010 Payment Error Rate Measurement (PERM) measurement cycles.

Table 5: Summary of Errors, Fiscal Years 2008 to 2010 PERM Measurement Cycles

Error type description	Number of errors	Percentage of total number of errors	Dollars in error	Percentage of total dollars in error
Eligibility review				
1. Undetermined	910	28.2%	\$349,677	9.3%
2. Not eligible	814	25.3%	299,920	8.0%
3. Eligible with ineligible services	122	3.8%	75,979	2.0%
4. Liability understated	145	4.5%	30,459	0.8%
5. Liability overstated	37	1.1%	8,034	0.2%
6. Managed care error – ineligible for managed care	8	0.2%	1,270	0.0%
7. Managed care error – eligible for managed care but improperly enrolled	4	0.1%	181	0.0%
Fee-for-service (FFS) review				
Medical review				
8. Insufficient documentation	298	9.2%	940,585	25.0%
9. Diagnosis coding error	59	1.8%	454,793	12.1%
10. No documentation	140	4.3%	450,961	12.0%
11. Number of units error	161	5.0%	158,263	4.2%
12. Policy violation	55	1.7%	112,657	3.0%
13. Procedure coding error	55	1.7%	94,708	2.5%
14. Medically unnecessary service	13	0.4%	68,758	1.8%
15. Administrative/other	26	0.8%	14,635	0.4%
16. Unbundling	1	0.0%	92	0.0%
Data processing review				
17. Administrative/other	43	1.3%	195,937	5.2%
18. Noncovered service	78	2.4%	188,242	5.0%
19. Third-party liability	12	0.4%	62,634	1.7%
20. Logic edit	9	0.3%	59,281	1.6%
21. FFS claim for a managed care service	6	0.2%	50,772	1.4%
22. Pricing error	128	4.0%	45,233	1.2%
23. Duplicate item	11	0.3%	45,186	1.2%
24. Data entry error	7	0.2%	14,778	0.4%
25. Managed care payment error	1	0.0%	0	0.0%

**Appendix VI: Types of Errors Identified in
Payment Error Rate Measurement Reviews**

Error type description	Number of errors	Percentage of total number of errors	Dollars in error	Percentage of total dollars in error
Managed care review				
Data processing review				
26. Noncovered service	40	1.2%	22,146	0.6%
27. Logic edit	1	0.0%	9,053	0.2%
28. Duplicate item	5	0.2%	3,493	0.1%
29. Managed care payment error	31	1.0%	533	0.0%
30. Pricing error	1	0.0%	166	0.0%
31. Administrative/other	1	0.0%	31	0.0%
Total	3,222	100.0%	\$3,758,457	100.0%

Source: GAO analysis of Centers for Medicare & Medicaid Services' error data.

Appendix VII: Comments from the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 12 2013

Beryl H. Davis
Director, Financial Management and Assurance
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Davis:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicaid: Enhancements Needed for Improper Payments Reporting and Related Corrective Action Monitoring" (GAO-13-229).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID: ENHANCEMENTS NEEDED FOR IMPROPER PAYMENTS REPORTING AND RELATED CORRECTIVE ACTION MONITORING" (GAO-13-229)

The Department appreciates the opportunity to review and comment on this draft report.

See comment 1.

Although HHS agrees with many of GAO's recommendations, we have provided extensive technical comments to GAO's draft report to clarify several important issues regarding CMS's management and implementation of the Payment Error Rate Reduction (PERM). Throughout the report, GAO makes statements implying that until CMS establishes procedures for considering changes to initially reported state-level error rates, CMS is impaired in its ability to ensure its reported Medicaid improper payment estimates are reliable. HHS believes such statements are misleading and suggest that past Medicaid error rates reported by CMS have been unreliable. The reported Medicaid improper payment estimate for fiscal year 2012 was 7.1 percent. This estimate included reviews of fiscal years 2009, 2010, and 2011 Medicaid payments. CMS recalculated the 2012 national Medicaid improper payment rate to incorporate any state-level error rate corrections from fiscal years 2009 and 2010 and the rate remained 7.1 percent. These state-level recalculations did not impact the national Medicaid improper payment rate.

See comment 1.

The draft report also references OMB's *Standards and Guidelines for Statistical Surveys* and suggests this guidance be the basis for determining how to handle PERM related data corrections. CMS points out that OMB guidance is not applicable to the PERM program; the PERM program is subject to OMB implementing guidance for Improper Payments Elimination and Recovery Act of 2010, Memorandum M-11-16. OMB did not include guidance for handling unscheduled corrections to data in OMB Memorandum M-11-16.

See comment 1.

The draft report also references the inability of CMS's review contractor to review medical claims not submitted during the audit cycle due to time constraints. It should be noted, the review contractor will complete the review of all medical records received by the cycle cut-off prior to error rate calculation. According to the PERM manual, if a Review Contractor receives late documentation prior to the cycle cut-off date for error rate calculation and reporting purposes, it will review the records and, if justified, revise the error finding. This characterization is inaccurate and we have asked GAO to modify this statement in our technical comments.

See comment 1.

HHS continues to caution GAO about including the state error rates identified in Appendix III, as we are concerned that readers will use the rates for comparison purposes when they should not. Due to the variation of states' sizes, overall program variations, and how states implement and administer their program, we do not encourage comparisons based solely on state rates.

CMS's implementation of PERM program complies with OMB's implementing guidance for the Improper Payments Elimination and Recovery Act of 2010. CMS coordinates Medicaid improper payment measurement closely with the states. CMS frequently communicates with states through regularly scheduled cycle calls, webinars, monthly calls, emails, the PERM website, and ad-hoc calls as necessary. We continuously improve and refine the PERM process with the states as we gain experience and feedback from entities such as GAO.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID: ENHANCEMENTS NEEDED FOR IMPROPER PAYMENTS REPORTING AND RELATED CORRECTIVE ACTION MONITORING" (GAO-13-229)

The GAO recommendations and HHS response to those recommendations are discussed below.

Recommendation 1

Update PERM Medicaid improper payment reporting procedures to provide for considering any corrections to state-level improper payment error data subsequent to the cut-off date that would have significant impact on any of the 3 years used to develop the rolling average for the reported national Medicaid improper payment estimate.

HHS Response

HHS concurs and will consider revising the improper payment reporting procedures to take into account corrections to state-level improper payment error data. In order to calculate and report improper payment rates in HHS's Agency Financial Report (AFR) each November, it is essential that CMS set a cut-off date so that the cycle can end prior to the improper payment rate reporting.

HHS believes it is important to note that state-level error rate corrections that occurred after the improper payment reporting in the AFR did not affect the accuracy of the reported national error rate. The reported Medicaid improper payment estimate for fiscal year 2012 was 7.1 percent. This estimate included reviews of fiscal years 2009, 2010, and 2011 Medicaid payments. Based on this GAO review, we recalculated the 2012 national Medicaid improper payment rate to incorporate any state-level error rate corrections for fiscal years 2009 and 2010 and the rate remained 7.1 percent. These state-level recalculations did not impact the national Medicaid improper payment rate.

Recommendation 2

Revise the PERM manual to provide that states (1) analyze all deficiencies, negative case errors, technical errors, and minimal dollar errors identified in PERM reviews to determine if any corrective actions, if cost-effective, are needed to prevent such errors in the future, and (2) document the results of their analysis.

HHS Response

HHS concurs and CMS will modify the PERM manual accordingly. CMS relies on frequent communication with states through regularly scheduled cycle calls, webinars, emails, the PERM website, and ad-hoc calls as necessary to provide guidance relating to Corrective Action Plans (CAP). The PERM manual specifies that states should use the most cost effective corrective actions when situations arise where the costs of implementing a corrective action exceed the benefits. HHS agrees that formally documenting this guidance in writing may be beneficial to states and CMS will update the PERM manual accordingly.

See comment 1.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID: ENHANCEMENTS NEEDED FOR IMPROPER PAYMENTS REPORTING AND RELATED CORRECTIVE ACTION MONITORING" (GAO-13-229)

Recommendation 3

Clarify guidance in the PERM manual, and on the PERM website, on the required elements to be included in a CAP and the specific actions states are to take each measurement cycle to (1) effectively prepare and evaluate their current cycle's CAP, and (2) provide updates to their previous cycle's CAP.

HHS Response

HHS concurs and will update the PERM manual and relevant documents on the PERM website accordingly. Supplying consistent and clear written guidance to states through our PERM manual and website will better assist states in complying with the PERM CAP requirements.

Recommendation 4

Finalize draft policies and procedures to clarify specific CMS officials' roles and responsibilities for monitoring states' corrective actions to ensure, at a minimum, that (1) the CAPs contain all of the required elements and completely address errors identified in the PERM reviews, and (2) states are making progress on implementing corrective actions.

HHS Response

HHS concurs and, as mentioned in the report, these documents are currently under development. The Division of Error Rate Measurement (DERM) within CMS is working collaboratively with CMS's Medicaid Integrity Group (MIG) and CMS Regional Offices to develop standard operating procedures outlining the roles of DERM, MIG, and the Regional Offices during state CAP review. CMS is also developing check lists and review guides that will be utilized when reviewing state CAPs to ensure the CAPs contain all the required elements, adequately address errors identified through PERM, and specify implementation progress. These documents are currently in draft stage and CMS is testing these procedures while reviewing fiscal year 2011 state CAPs. Based on this experience, CMS will refine the protocols as necessary and finalize the policies and procedures.

TECHNICAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID: ENHANCEMENTS NEEDED FOR IMPROPER PAYMENTS REPORTING AND RELATED CORRECTIVE ACTION MONITORING" (GAO-13-229)

See comment 1.

1. On the highlights page and throughout the report, GAO makes statements implying that until CMS establishes procedures for considering changes to initially reported state-level error rates, CMS is impaired in its ability to ensure its reported Medicaid improper payment estimates are reliable. GAO specifically states that "Until CMS establishes procedures for considering changes to initially reported state-level error rates that would be significant to the national error rate, CMS is impaired in its ability to ensure its reported estimate on the extent of national Medicaid improper payments is reliable." CMS believes these statements may mislead the reader to believe that past Medicaid error rates reported by CMS have been unreliable. The reported Medicaid improper payment estimate for fiscal year 2012 was 7.1 percent. This estimate included reviews of fiscal years 2009, 2010, and 2011 Medicaid payments. CMS recalculated the 2012 national Medicaid improper payment rate to incorporate any state-level error rate corrections from fiscal years 2009 and 2010 and the rate remained 7.1 percent. These state-level recalculations did not impact the national Medicaid improper payment rate. HHS suggests that GAO revise these statements to specify that the majority of past state-level error rate corrections have not been significant and that without a process to consider this more current data on states' reported improper payment error rates, the reliability of CMS's future reported national estimates may be adversely affected.

See comment 2.

2. While the PERM manual is not the only avenue by which CMS provides guidance on PERM, the PERM manual and website are the primary forms of guidance recognized in the report. CMS also uses frequent communication with the states through regularly scheduled cycle calls, webinars, monthly calls, emails, the PERM website, and ad-hoc calls as necessary. HHS suggests that GAO specify throughout the report that improvements are needed to CMS's written guidance to states on CAPs since some PERM guidance is currently only given to states through verbal and email communication.

See comment 1.

3. GAO states in this report that "OMB has identified as a best practice that agencies should establish a policy for handling unscheduled corrections to data such as including threshold criteria identifying conditions under which data will be corrected and redisseminated." GAO's references to OMB's *Standards and Guidelines for Statistical Surveys* are inapplicable to improper payment rate measurements. Improper payment rate measurements are required to follow OMB implementing guidance for the Improper Payments Elimination and Recovery Act of 2010, OMB Memorandum M-11-16. OMB did not include guidance for handling unscheduled corrections to data in OMB Memorandum M-11-16. HHS recommends deleting these references from the report.

See comment 3.
Page numbers in the draft report may differ from those in this report.

4. Figure 1 on page 6 of the report inaccurately categorizes PERM process details by year. The correct activities by year are as follows:

- Year 1: Develop universe; Select samples; Begin eligibility reviews
- Year 2: Continue drawing samples; Begin FFS and managed care reviews
- Year 3: Continue and finalize reviews; State error rates determined; National error rate calculated; Reporting; Corrective action plans

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See comment 2.

5. Footnote 15 on page 7 states, "The weighted national component error rates do not total the national Medicaid improper payment error rate due to the correction factor." This statement is incorrect. The component error rates do not sum to the national Medicaid rate because the national Medicaid rate is a weighted average of fee-for-service (FFS) and managed care plus eligibility. A small correction factor is then subtracted and is an additional reason the three component rates do not add up.

See comment 2.

6. Footnote on page 8 states, "The weighted national average for managed care does not average across for 2008, 2009, and 2010 due to rounding." However, the weighted national average for managed care does not average across because the rolling rates are not arithmetic averages. Rather, they are weighted by expenditures. By extension, the component rates cannot be simply averaged. For example, the FFS rolling rates are three years of rolling rates weighted by FFS expenditures. In this instance, it is simple luck that the FFS, eligibility, and overall rates happened to average.

See comment 1.

7. The statement "For example, states may request a recalculation when medical records for a claim were received prior to the cycle cut-off date but CMS' review contractor did not have time to complete the review..." on page 11 is inaccurate. The review contractor will complete the review of all medical records received by the cycle cut-off prior to error rate calculation. Per the PERM manual, "If the Review Contractor receives late documentation prior to the cycle cut-off date for error rate calculation and reporting purposes (generally the second July 15 of a measurement cycle), it will review the records and, if justified, revise the error finding." HHS suggests rewording this sentence to say, "For example, states may request a recalculation when information supporting a claim as correctly paid was submitted to CMS after the cycle cut-off date..."

See comment 2.

8. Page 12 of the report states, "While CMS aims for a cycle cut-off date of July 15 - 4 months prior to the reporting date, the CMS cycle manager may extend the cycle cut-off date depending on the progress of the PERM reviews." HHS suggests specifying that the PERM cycle has never been cut-off on July 15. Delays are inevitable and PERM due dates are not always met for various reasons (i.e. if a state is implementing a new Medicaid Management Information System during the PERM cycle they may encounter issues that lead to late submission of data to the PERM federal contractor). Therefore, for every cycle CMS has postponed the cycle cut-off to allow the process to complete as much as possible while still permitting CMS to report an improper payment rate timely in the agency final report.

See comment 2.

9. Page 12 of the report gives two examples of CMS issuing revised error rates to states. HHS believes it is important for the reader to understand the timing of these discoveries compared to error rate reporting.

- HHS suggests revising the sentence, "...CMS issued a revised rate to one state for its eligibility reviews for the fiscal year 2008 measurement cycle because CMS and the state discovered that the amount of dollars in error was reported incorrectly by the state." to the following, "CMS issued a revised rate to one state for its eligibility

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See comment 2.

reviews for the fiscal year 2008 measurement because in January 2010, two months after error rate reporting, CMS and the state discovered the amount of dollars in error was reported incorrectly by the state."

- HHS recommends changing the sentence, "CMS issued a post cut-off date revised rate to a state for its FFS reviews because CMS received additional documentation from providers after the cycle cut-off date" to "In December 2009, one month after error rate reporting, CMS issued a post cut-off date revised rate to a state for its FFS reviews because CMS received additional documentation from providers after the cut-off date for official error rate calculations."

See comment 2.

10. HHS recommends deleting the following two statements on page 12: "This decreased error rate would have resulted in an approximately \$400 million decrease to the estimated improper payments for this state" and "This decreased error rate would have resulted in an approximately \$31 million decrease to the estimated improper payments for this state." The improper payment rate percentage point change shows the real impact of error rate revisions and is already stated in the report. CMS does not report state-level estimated improper payments and this statistic is solely used to calculate the improper payment rate itself. Including these statements in the report may cause the reader to misinterpret the true impact of the revisions which GAO has already stated in the report.

See comment 2.

11. The definition of technical error on page 17 should be revised to read, "A technical error is an error where the eligibility caseworker did not act in accordance with state or federal policy, however, it did not result in an erroneous eligibility determination or result in a difference between the amount that was paid and the amount that should have been paid."

See comment 2.

12. Page 19 of the report states, "Although CMS's PERM manual requires states to complete and submit a CAP based on the errors found during the PERM process, this guidance makes no exception for small errors—sometimes due to rounding—which may result in states incurring costs to implement corrective actions that exceed the dollar amount of the payment error." HHS believes this statement may mislead the reader for two reasons:

- There are many instances when a corrective action may exceed the dollar amount of the payment error identified in the PERM sample. PERM may sample just one claim that was affected by, say, a system issue. However, the issue identified could affect thousands of other claims that are being processed by the state. Therefore, the corrective action may exceed the dollar amount of the PERM error, but prevent a large sum of improper payments.
- While the PERM guidance requires that states address all errors in their CAPs, it does not require states to implement particular corrective actions for every error. CMS does not believe requiring a state to address every error in their CAP would result in states incurring costs to implement non-effective corrective actions.

See comment 4.

See comment 2.

13. Page 19 of the report states, "While this is a sizeable investment to address these minimal dollar errors, the state now plans to redesign its system in order to avoid these types of

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PERM errors going forward." HHS believes this may mislead the reader to think that the state continues to pursue a non-cost effective corrective action under the advisement of CMS. Before the fiscal year 2011 PERM cycle was complete, CMS stated the following through email communication with this state, "State's Corrective Action Plans should take into consideration the cost benefit analysis for any corrective action when developing their Corrective Action Plan...If the State determines that the cost of implementing a corrective action outweighs the benefits then the final decision of implementing the corrective action is the State's decision. This cost benefit analysis and final decision can be documented in the State's Corrective Action Plans submitted to CMS."

See comment 4.

14. Page 24 of the report states, "Also, while states are currently required to address all errors, doing so may not be the most efficient and effective use of state resources for errors that do not pose a risk of significantly impacting future improper payments." HHS would like to point out that there is a difference between addressing all errors and implementing specific actions for each error. CMS requires states to address each error in their written CAP which includes stating what actions are being implemented or why an action is not being implemented for each error. CMS does not, however, require states to implement particular actions for each error.

GAO Comments

The following are GAO's comments on the Department of Health and Human Service's (HHS) letter dated March 13, 2013.

1. See the "Agency Comments and Our Evaluation" section of this report.
2. We agree with HHS's comment and modified the report as appropriate.
3. We agree in part with HHS's comment and incorporated clarifying language to the figure source and Payment Error Rate Measurement (PERM) process details. Also, we added a figure note to acknowledge that certain year 1 and year 2 activities may be delayed until years 2 and 3, respectively.
4. We clarified the report to acknowledge that the Centers for Medicare & Medicaid Services' (CMS) written guidance does not indicate that states could address an error by stating why an action is not being implemented. This relates to our second recommendation, with which HHS concurred, that such guidance should be formally documented in CMS's PERM Manual.

Appendix VIII: GAO Contact and Staff Acknowledgments

GAO Contact

Beryl H. Davis, (202) 512-2623 or davisbh@gao.gov

Staff Acknowledgments

In addition to the contact named above, Phillip McIntyre (Assistant Director), Gabrielle Fagan, Kerry Porter, and Carrie Wehrly made key contributions to this report. Also contributing to this report were Carl Barden, Sharon Byrd, Francine DeVecchio, Patrick Frey, Wilfred Holloway, Jason Kelly, and Jason Kirwan.

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