DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	4-12-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100417	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Ms. Forkner, Deps	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

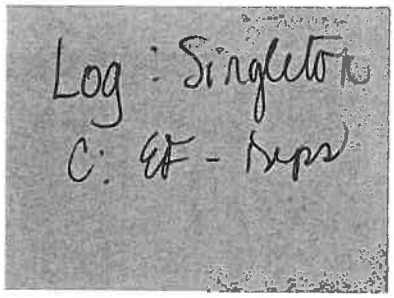
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR - 8 2010

Report Number: A-06-09-00079



Ms. Emma Forkner
Medicaid Director
Department of Health and Human Services
1801 Main Street, P.O. Box 8206
Columbia, SC 29202

Dear Ms. Forkner:

Enclosed is the U.S. Department of Health & Human Services, Office of Inspector General (OIG), final report entitled *Analyses of Improper Payments Identified During the Payment Error Rate Measurement Program Reviews in 2006 and 2007.*

The American Recovery and Reinvestment Act (the Recovery Act) authorizes fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn and will provide an estimated $87 billion in additional Medicaid funding. The enclosed report highlights Medicaid payment errors identified in the 2006 and 2007 Payment Error Rate Measurement program and should help your State ensure that future Medicaid payments, including those funded by the Recovery Act, comply with Federal requirements.

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

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph J. Green, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through email at Joe.Green@oig.hhs.gov. Please refer to report number A-06-09-00079 in all correspondence.

Sincerely,

Joseph E. Vengrin
Deputy Inspector General
for Audit Services

Enclosure

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

ANALYSIS OF IMPROPER PAYMENTS IDENTIFIED DURING THE PAYMENT ERROR RATE MEASUREMENT PROGRAM REVIEWS IN 2006 AND 2007

Daniel R. Levinson
Inspector General

April 2010
A-06-09-00079

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. The Federal Government pays its share of States' medical assistance expenditures based on the Federal medical assistance percentage (FMAP), which varies depending on each State's relative per capita income. To ensure proper and efficient payment of Medicaid claims, the Act requires States to have claim payment procedures that provide for prepayment and postpayment claims review.

The American Recovery and Reinvestment Act of 2009 (the Recovery Act), P.L. No. 111-5, provides fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provides an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAP.

The Improper Payments Information Act of 2002 (IPIA) requires the head of each Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. The IPIA also requires the Director of the Office of Management and Budget (OMB) to prescribe guidance on implementing IPIA requirements. OMB identified Medicaid as a program at risk for significant erroneous payments and directed the Department of Health & Human Services to report the estimated Medicaid error rate in its Performance and Accountability Reports.

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and OMB requirements for measuring improper Medicaid payments. The PERM program measures improper payments from a sample of Medicaid claims in 17 different States (including the District of Columbia as a State) every year; thus, each State is chosen only once every 3 years. CMS used three Federal contractors to administer the PERM program: a statistical contractor, documentation/database contractor, and review contractor. The review contractor conducts medical reviews and data processing reviews on the sample claims to determine whether they were paid correctly. CMS sends each State an error report detailing the types of errors identified during its PERM program review and requires the State to develop corrective actions to address the causes of the errors.

The PERM results for the 17 States reviewed each year are used to calculate a national Medicaid error rate. In fiscal year (FY) 2006, the PERM program measured improper payments in Medicaid's fee-for-service component. CMS estimated that the national Medicaid error rate was 4.7 percent, or $6.6 billion (Federal share) in improper payments. For FY 2007 and future years, CMS intended for the PERM program to determine whether States appropriately decided beneficiary eligibility and to measure improper payments made in the fee-for-service and managed care components of Medicaid. CMS estimated that the combined eligibility, fee-for-service, and managed care error rate for FY 2007 was 10.5 percent, or $18.6 billion (Federal share) in improper payments.

The Office of Inspector General reviews the PERM program. Our work has included testing and analysis of the PERM sampling and estimation methodology, the medical records request process, medical review, and the error estimation calculation.

OBJECTIVE

Our objective was to analyze improper payment information related to the types of errors and service categories included in the FY 2006 and 2007 PERM program reviews.

SUMMARY OF RESULTS

Of the 1,356 medical review errors we analyzed, 4 types accounted for 78 percent of the errors and 95 percent of the net improper Medicaid overpayments. The four error types were insufficient documentation, no documentation, services that violated State policies, and medically unnecessary services. The 1,356 errors included 23 service categories, 6 of which accounted for 67 percent of the errors and 95 percent of the net improper Medicaid overpayments. The six service categories were nursing facility, inpatient hospital, other services—Home and Community-Based Services waivers, intermediate care facility for the mentally retarded, prescribed drugs, and physician.

Of the 202 data processing errors we analyzed, 4 types accounted for 78 percent of the errors and 64 percent of the net improper Medicaid overpayments. The four error types were pricing errors, noncovered services errors, rate cell errors for managed care claims, and errors in the logic edits of claim processing systems. The 202 errors represented 18 service categories, 6 of which accounted for nearly 73 percent of the errors and 79 percent of the net improper Medicaid overpayments. The six service categories were inpatient hospital, nursing facility, capitated care, prescribed drugs, physician, and outpatient hospital.

RECOMMENDATION

For future PERM years, we recommend that CMS develop and provide to the States analytical data similar to that contained in this report and encourage the States to use the data to help ensure that payments, including those funded by the Recovery Act, comply with Federal requirements.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

CMS concurred with the recommendation and said that it would be implemented starting with the FY 2010 measurement cycle. CMS's comments are included in their entirety as Appendix E.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the States have considerable flexibility in designing and operating their Medicaid programs, they must comply with applicable Federal requirements.

To ensure proper and efficient payment of Medicaid claims, section 1902(a)(37)(B) of the Act requires States to have claim payment procedures that provide for prepayment and postpayment claims review, including review of appropriate data about providers, patients, and the nature of the services for which payments are claimed.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of States' medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on each State's relative per capita income.[1] Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time.

Temporary Increase in Federal Medical Assistance Percentages

The American Recovery and Reinvestment Act of 2009 (the Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provides an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Section 5000 of the Recovery Act provides for these increases to help avert cuts in health care payment rates, benefits, or services and to prevent changes to income eligibility requirements that would reduce the number of individuals eligible for Medicaid.

Sections 5001(a), (b), and (c) of the Recovery Act provide that a State's increased FMAP during the recession adjustment period will be no less than its 2008 FMAP increased by 6.2 percentage points and that a State may receive an increase greater than 6.2 percentage points based on increases to its average unemployment rate. (See Appendix A for a list of the increased FMAPs

[1] The FMAP is also used to determine the Federal Government's share of certain child support enforcement collections, Temporary Assistance for Needy Families contingency funds, a portion of the Child Care and Development Fund, and foster care and adoption assistance payments.

and Federal grant awards for the 50 States and the District of Columbia for the first and second quarters of fiscal year (FY) 2009.)[2]

Improper Payments Information Act of 2002

The Improper Payments Information Act of 2002 (IPIA), P.L. No. 107-300, requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. In addition, for any program or activity with estimated improper payments exceeding $10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments. Improper payments are defined as payments that should not have been made or that were for incorrect amounts and include payments (1) to ineligible recipients, (2) for ineligible services, (3) that were duplicated, (4) for services not received, and (5) that do not account for credit for applicable discounts.

Pursuant to section 2(f) of the IPIA, the Director of the Office of Management and Budget (OMB) must prescribe guidance on implementing IPIA requirements. OMB's implementation guidance, memorandum M-03-13, defined significant improper payments as "annual erroneous payments in the program exceeding both 2.5 percent of program payments and $10 million" and indicated that the estimated amount should be statistically valid. OMB identified Medicaid as a program at risk for significant erroneous payments and directed the Department of Health & Human Services to report the estimated Medicaid error rate in its Performance and Accountability Reports.

Payment Error Rate Measurement Program

CMS developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and OMB requirements for measuring improper Medicaid payments.[3] For FY 2006, CMS intended for the PERM program to measure improper payments made in Medicaid's fee-for-service component. CMS estimated that the national Medicaid error rate was 4.7 percent, or $6.6 billion (Federal share) in improper payments. For FY 2007 and future years, CMS intended for the PERM program to determine whether States appropriately decided beneficiary eligibility and to measure improper payments made in the fee-for-service and managed care components of Medicaid. CMS estimated that the combined eligibility, fee-for-service, and managed care error rate was 10.5 percent, or $18.6 billion (Federal share) in improper payments. Additionally, CMS reported separate error rates for the fee-for-service (8.9 percent), managed care (3.1 percent), and eligibility (2.9 percent) components for FY 2007.

CMS used three Federal contractors to administer the PERM program:

- a statistical contractor that collected the claims universes from the States, selected a sample of claims to be reviewed from each State, and ultimately calculated the State and national error rates for Medicaid;

[2] Because the Recovery Act was enacted during the second quarter of FY 2009, it includes a special rule in section 5001(c)(4)(C) that specifies how to calculate the increased FMAPs for the first two quarters of FY 2009. Based on this calculation, each State's increased FMAP was the same for both quarters.

[3] See 71 Fed. Reg. 51050 (August 28, 2006) and 42 CFR part 431, subpart Q.

- a documentation/database contractor that collected Medicaid medical policies from each State and medical records from the sampled providers; and

- a review contractor that performed the medical and data processing reviews on the sampled claims to determine whether the claims were paid correctly.

The review contractor reviewed medical records from the sampled claims to determine whether, among other things, the types of services provided were in accordance with State policy and guidelines, the services provided were medically necessary, and the medical record documentation was complete. The review contractor also conducted data processing reviews to determine whether claims had been processed correctly by the States' claims processing systems. (See Appendix B for the medical and data processing review error codes and definitions the review contractor used.)

CMS sends each State an error report detailing the types of errors identified during its PERM program review and requires the State to review the errors, determine the root cause of the errors, and develop corrective actions to address those causes. CMS also expects States to monitor implemented corrective actions to determine whether the actions are effective and whether goals are being reached.

The PERM program measures improper payments in 17 different States (including the District of Columbia as a State) every year; thus, each State is measured only once every 3 years on a cyclical basis. Table 1 shows the cycle of States from FYs 2006 through 2008.

Table 1: States Selected for PERM Over the 3-Year Cycle

FY 2006	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
FY 2007	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
FY 2008	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

Note: The cycle repeats starting in FY 2009.

The Office of Inspector General reviews the PERM program. Our work has included testing and analysis of the PERM sampling and estimation methodology, the medical records request process, medical review, and the error estimation calculation.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to analyze improper payment information related to the types of errors and the service categories included in the FY 2006 and 2007 PERM program reviews.

Scope

The PERM review contractor identified 1,541 medical review errors and 219 data processing errors in its sample of claims. However, information was missing from 185 medical review errors and 17 data processing errors, precluding us from classifying those claims by medical service category. We analyzed the remaining sample items from the FY 2006 and 2007 PERM program reviews that were paid in error: 1,356 sample items with medical review errors that resulted in improper Medicaid payments totaling $1,432,029 and 202 sample items with data processing errors that resulted in improper Medicaid payments totaling $107,308.[4]

We limited our review to Medicaid information that was related to the FY 2006 and 2007 PERM reviews and provided by CMS's PERM program contractors. We did not independently verify the data provided by the contractors. The audit objective did not require that we identify or review the PERM program contractors' internal control systems.

We performed our audit work from May through July 2009.

Methodology

To accomplish our objective, we:

- reviewed the Recovery Act,
- reviewed CMS PERM reports for FYs 2006 and 2007,
- obtained and analyzed PERM sample-item documentation from the documentation/database contractor,
- obtained and analyzed PERM error data from the documentation and statistical contractors,
- reviewed the reasons listed for the data processing errors,
- matched the sample documentation to the error data to identify the type of service for sample items with improper payments,

[4] Improper payments were measured as both overpayments and underpayments the States made. To calculate the net overpayments, we subtracted the underpayment amounts from the overpayment amounts.

- determined the service category using service codes and definitions created for the Medicaid Statistical Information System (MSIS) and additional service codes CMS created for the PERM program, and

- combined the error data for FYs 2006 and 2007 and analyzed it by type of error and service category.

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

RESULTS OF REVIEW

We analyzed 1,356 medical review errors and 202 data processing errors identified by the PERM review contractor. Of the 1,356 medical review errors, 4 types of errors represented 78 percent of the errors and 95 percent of the net improper Medicaid overpayments. The medical review errors included 23 service categories, 6 of which represented 67 percent of the errors and 95 percent of the net improper Medicaid overpayments.

Of the 202 data processing errors, 4 types of errors represented 78 percent of the errors and 64 percent of the net improper Medicaid overpayments. The data processing errors included 18 service categories, 6 of which represented nearly 73 percent of the errors and 79 percent of the net improper Medicaid overpayments.

The total payment for Medicaid sample items in error was $1,539,337.

MEDICAL REVIEW ERRORS

Errors by Type

Of the 1,356 medical review errors, 4 types of errors represented 78 percent of the errors and 95 percent of the net improper Medicaid overpayments. The four types of errors were insufficient documentation, no documentation, services that violated State policies, and medically unnecessary services. Table 2 provides more information about the four types of errors.

Table 2: Number and Percentage of Medical Review Errors and Dollar Amounts Related to the Four Most Frequent Errors by Type

Errors by Type	Amount of Improper Medicaid Overpayments	Amount of Improper Medicaid Underpayments	Number of Errors	Percentage of Errors
Insufficient documentation	$586,254	0	507	37.4%
No documentation	362,695	0	339	25.0%
Policy violation	230,485	0	175	12.9%
Medically unnecessary service	181,497	$695	32	2.4%

Errors by Service Categories

The 1,356 medical review errors included 23 service categories, 6 of which represented 67 percent of the errors and 95 percent of the net improper Medicaid overpayments. The six service categories were nursing facility, inpatient hospital, other services—Home and Community-Based Services waivers, intermediate care facility for the mentally retarded, prescribed drugs, and physician. Table 3 provides more information about these six service categories. (See Appendix C for additional information on errors related to service categories.)

Table 3: Number and Percentage of Medical Review Errors and Dollar Amounts Related to the Six Service Categories With the Highest Overpayments

Service Categories	Amount of Improper Medicaid Overpayments	Amount of Improper Medicaid Underpayments	Number of Errors	Percentage of All Errors
Nursing facility	$515,167	$864	182	13.4%
Inpatient hospital	334,301	9,565	103	7.6%
Other services—Home and Community-Based Services waivers	332,720	96	208	15.3%
Intermediate care facility for the mentally retarded	151,352	0	26	1.9%
Prescribed drugs	26,772	0	257	19.0%
Physician	13,415	298	132	9.7%

DATA PROCESSING ERRORS

Errors by Type

Of the 202 data processing errors, 4 types of errors represented 78 percent of the errors and 64 percent of the net improper Medicaid overpayments. The four types of errors were pricing errors, noncovered services errors, rate cell errors for managed care claims,[5] and errors in the logic edits of claim processing systems. Table 4 provides more information about the four types of errors.

Table 4: Number and Percentage of Data Processing Errors and Dollar Amounts Related to the Four Most Frequent Errors by Type

Errors by Type	Number of Errors	Percentage of All Errors	Amount of Medicaid Overpayments	Amount of Medicaid Underpayments
Pricing	85	42.0%	$1,936	$20,669[6]
Noncovered services	38	18.8%	68,057	285
Rate cell	21	10.4%	5,514	1,965
Logic edit	14	6.9%	16,416	316

Pricing errors were claim items for which payment did not correspond with the States' pricing schedules for those services. The reasons most cited for pricing errors were:

- Incorrect claim system calculations (including rounding) were made (43 errors).
- Rates were entered into the claim system incorrectly (13 errors).
- Incorrect patient liability was deducted from claim payments (10 errors).

Noncovered service errors were claim items in which State policies indicated that services were not payable under State plans or the coverage categories under which the recipients were eligible. The most frequently cited reasons for noncovered service errors were:

- The recipients were not shown as eligible in the claim systems on the dates of service (15 errors).
- Prior authorization was required but either was not shown on the claims or in the States' systems or was not current for the dates of service (12 errors).

[5] Rate cells are the combinations of eligibility and demographics (e.g., county of residence, age, sex) used to isolate medical utilization patterns for determining capitation payment rates that the State pays to managed care health plans. A rate cell error would occur, for example, when a State paid the capitation payment rate for a 28-year-old female residing in X County when the person selected for review was a 28-year-old male residing in X County.

[6] One inpatient hospital claim accounted for $17,335 of this underpayment amount.

Managed care was not included in the FY 2006 PERM review. In spite of this, incorrect rate cell errors for beneficiaries enrolled in managed care plans were more than 10 percent of the combined error total for FYs 2006 and 2007. The most common causes listed for these errors were:

- The wrong rate cell was used for a Medicare recipient who also had Medicaid coverage (14 errors).

- A Medicare rate cell was used for a non-Medicare recipient who had Medicaid coverage (5 errors).

Logic edit errors were instances in which a claim processing system edit was not in place because of State policy or a system edit was in place but was not working correctly and allowed payment. Two reasons were noted for these errors:

- A system edit should have stopped the payment (12 errors).

- A system edit was turned off (2 errors).

Errors by Service Categories

The 202 data processing errors included 18 service categories, 6 of which represented nearly 73 percent of the errors and 79 percent of the net improper Medicaid overpayments. The six service categories were inpatient hospital, nursing facility, capitated care, prescribed drugs, physician, and outpatient hospital. Table 5 provides more information about these six service categories. (See Appendix D for additional information on the number, types, and dollar amounts of errors for different service categories.)

Table 5: Number and Percentage of Data Processing Errors and Dollar Amounts Related to the Six Most Frequent Service Categories

Service Categories	Number of Errors	Percentage of All Errors	Amount of Improper Medicaid Overpayments	Amount of Improper Medicaid Underpayments
Inpatient hospital	32	15.8%	$27,897	$20,418
Nursing facility	30	14.9%	59,300	372
Capitated care[7]	28	13.9%	6,528	1,965
Prescribed drugs	23	11.4%	709	230
Physician	17	8.4%	11,372	20
Outpatient hospital	17	8.4%	2,879	638

[7] This category encompasses capitated payments to two MSIS type-of-service codes: 20—Health Maintenance Organization and Health Insuring Organization and 21—Prepaid Health Plans. We used the broad title of "Capitated care" because we could not determine which errors related to which MSIS codes.

For inpatient hospital items, pricing errors and logic edit errors represented 28 of the 32 errors. The 25 pricing errors totaled $1,034 in overpayments and $19,267 in underpayments. (One inpatient hospital item had a $17,335 underpayment because rates had been incorrectly entered into the State's claims-processing system.) The three logic edit errors resulted in overpayments totaling $14,428.

For nursing facility items, noncovered services errors and pricing errors represented 24 of the 30 errors. The 14 noncovered services errors totaled $55,513 in overpayments, with no underpayments; the 10 pricing errors totaled $186 in overpayments and $74 in underpayments.

For capitated care items, rate cell errors represented 21 of the 28 errors. The 21 errors totaled $5,514 in overpayments and $1,965 in underpayments. Three of the remaining errors, which related to noncovered services provided to a recipient who was not eligible on the date of service, resulted in an overpayment of $759.

For prescribed drug items, pricing errors represented 14 of the 23 errors. The 14 errors totaled $14 in overpayments and $230 in underpayments. Seven errors totaling $679 in overpayments occurred because the Medicaid payments should have been denied pending payment by a third party.

For physician services items, errors falling under the administrative/other category represented 8 of the 17 errors. The eight errors totaled $10,575 in overpayments.

Although 10 of the 17 outpatient hospital errors involved pricing, they totaled only $0.28 in overpayments and $129 in underpayments. One of the errors involved an item that was paid as a fee-for-service claim but should have been covered under a managed care plan. This error resulted in a $2,199 overpayment.

RECOMMENDATION

For future PERM years, we recommend that CMS develop and provide to the States analytical data similar to that contained in this report and encourage the States to use the data to help ensure that payments, including those funded by the Recovery Act, comply with Federal requirements.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

CMS concurred with the recommendation and said that it would be implemented starting with the FY 2010 measurement cycle. CMS's comments are included in their entirety as Appendix E.

APPENDIXES

APPENDIX A: STATES' FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND INCREASED GRANT PERCENTAGES AND AMOUNTS FOR THE FIRST TWO QUARTERS OF FISCAL YEAR 2009

State	FY 2009 FMAP	Increased FMAP for the First and Second Quarters of FY 2009	Percentage Point Increase	Increased Federal Grant Award
Alabama	67.98%	76.64%	8.66%	$169,785,318
Alaska	50.53%	58.68%	8.15%	41,574,129
Arizona	65.77%	75.01%	9.24%	351,481,067
Arkansas	72.81%	79.14%	6.33%	109,874,448
California	50.00%	61.59%	11.59%	1,991,907,534
Colorado	50.00%	58.78%	8.78%	140,911,583
Connecticut	50.00%	60.19%	10.19%	274,618,177
Delaware	50.00%	60.19%	10.19%	60,652,541
District of Columbia	70.00%	77.68%	7.68%	58,882,030
Florida	55.40%	67.64%	12.24%	817,026,895
Georgia	64.49%	73.44%	8.95%	339,608,197
Hawaii	55.11%	66.13%	11.02%	70,573,033
Idaho	69.77%	78.37%	8.60%	53,438,211
Illinois	50.32%	60.48%	10.16%	506,396,236
Indiana	64.26%	73.23%	8.97%	247,163,403
Iowa	62.62%	68.82%	6.20%	89,098,176
Kansas	60.08%	66.28%	6.20%	71,575,227
Kentucky	70.13%	77.80%	7.67%	205,301,202
Louisiana	71.31%	80.01%	8.70%	229,959,088
Maine	64.41%	72.40%	7.99%	94,547,202
Maryland	50.00%	58.78%	8.78%	275,508,598
Massachusetts	50.00%	58.78%	8.78%	896,759,179
Michigan	60.27%	69.58%	9.31%	464,364,309
Minnesota	50.00%	60.19%	10.19%	356,191,144
Mississippi	75.84%	83.62%	7.78%	143,364,649
Missouri	63.19%	71.24%	8.05%	270,528,865
Montana	68.04%	76.29%	8.25%	34,248,946
Nebraska	59.54%	65.74%	6.20%	47,843,363
Nevada	50.00%	63.93%	13.93%	90,310,490
New Hampshire	50.00%	56.20%	6.20%	31,531,287
New Jersey	50.00%	58.78%	8.78%	362,234,506
New Mexico	70.88%	77.24%	6.36%	95,239,707
New York	50.00%	58.78%	8.78%	2,070,832,598
North Carolina	64.60%	73.55%	8.95%	439,570,159
North Dakota	63.15%	69.95%	6.80%	18,837,293

State	FY 2009 FMAP	Increased FMAP for the First and Second Quarters of FY 2009	Percentage Point Increase	Increased Federal Grant Award
Ohio	62.14%	70.25%	8.11%	$500,169,636
Oklahoma	65.90%	74.94%	9.04%	174,758,013
Oregon	62.45%	71.58%	9.13%	155,826,609
Pennsylvania	54.52%	63.05%	8.53%	680,278,921
Rhode Island	52.59%	63.89%	11.30%	93,509,354
South Carolina	70.07%	78.55%	8.48%	175,478,668
South Dakota	62.55%	68.75%	6.20%	20,496,315
Tennessee	64.28%	73.25%	8.97%	342,931,044
Texas	59.44%	68.76%	9.32%	952,186,421
Utah	70.71%	77.83%	7.12%	53,362,783
Vermont	59.45%	67.71%	8.26%	45,464,332
Virginia	50.00%	58.78%	8.78%	252,659,121
Washington	50.94%	60.22%	9.28%	339,330,717
West Virginia	73.73%	80.45%	6.72%	76,479,599
Wisconsin	59.38%	65.58%	6.20%	163,109,663
Wyoming	50.00%	56.20%	6.20%	15,922,133
Total				**$15,563,702,119**

FY = fiscal year
FMAP = Federal medical assistance percentage

APPENDIX B: MEDICAL AND DATA PROCESSING REVIEW ERROR CODES AND DEFINITIONS

Medical Review Error	Definition
No documentation	The provider did not respond to the request for records within the 60-day timeframe.[1]
Insufficient documentation	The provider did not return requested information or did not submit sufficient documentation for the reviewer to determine whether the claim should have been paid.
Procedure coding error	The provider performed a procedure but billed an incorrect procedure code.
Diagnosis coding error	The provider billed using an incorrect diagnosis.
Unbundling	The provider billed for the separate components of a procedure code when one inclusive procedure code should have been billed.
Number of unit(s) error	The provider billed for an incorrect number of units for a particular service.
Medically unnecessary service	The provider billed for a service determined to have been medically unnecessary based on information in the patient's medical record.
State policy violation	Either the provider billed and was paid for a service that was not in agreement with State policy or the provider billed but was not paid for a service that, according to State policy, should have been paid.
Administrative/other	A payment error was discovered during a medical review but was not one of the other errors.

[1] The timeframe for FY 2006 was 90 days.

Data Processing Error	Definition
Duplicate item	An exact duplicate of the unit was paid.
Noncovered service	State policies indicate that the service was not payable under the State plan or the coverage category for which the person was eligible.
Fee-for-service claim for a managed care service	The beneficiary was enrolled in a managed care plan, which should have covered the service.
Third-party liability	A third-party insurer was liable for all or part of the payment.
Pricing error	Payment for the service did not correspond with the pricing schedule for that service.
Logic edit	Either a system edit was not in place because of policy or a system edit was in place but was not working correctly (e.g., incompatibility between gender and procedure or ineligible beneficiary or provider).
Data entry error	A clerical error was made in the data entry of the sampling unit.
Rate cell error	The beneficiary was enrolled in managed care and payment was made for the wrong rate cell.
Managed care payment error	The beneficiary was enrolled in managed care but was assigned the wrong payment amount.
Administrative/other	A payment error was discovered during a data processing review but was not one of the other error categories.

APPENDIX C: SUMMARY OF CLASSIFIABLE MEDICAL REVIEW ERRORS AND THE RESULTING OVERPAYMENTS AND UNDERPAYMENTS FOR EACH TYPE

Medicaid Statistical Information System Numerical Codes and Definitions		Number of Errors	Percentage of Errors	Total Payment for Sample Items With Errors	Amount of Overpayment	Amount of Underpayment	Net Overpayment Amount	Percentage of Net Overpayment
1	Inpatient hospital	103	7.6%	$615,801	$334,301	$9,565	$324,736	22.7%
2	Mental hospital services for the aged	1	0.1%	657	657	0	657	0.0%
4	Inpatient psychiatric under 21	7	0.5%	5,283	1,467	0	1,467	0.1%
5	Intermediate care facility for mentally retarded	26	1.9%	171,022	151,352	0	151,352	10.6%
7	Nursing facility	182	13.4%	521,522	515,167	864	514,303	35.9%
8	Physician	132	9.7%	19,347	13,415	298	13,117	0.9%
9	Dental	27	2.0%	4,126	4,057	10	4,047	0.3%
10	Other licensed practitioners' services (could not classify more specifically)	8	0.6%	333	92	0	92	0.0%
	Other licensed practitioners—podiatrists	1	0.1%	18	0	0	0	0.0%
	Other licensed practitioners—psychologists	1	0.1%	60	60	0	60	0.0%
	Other licensed practitioners—optometrists	2	0.1%	7	0	7	(7)	0.0%
11	Outpatient hospital	45	3.3%	12,310	11,139	0	11,139	0.8%
12	Clinic services	46	3.4%	11,190	9,306	30	9,276	0.6%
13	Home health services (could not classify more specifically)	20	1.5%	2,442	1,760	40	1,720	0.1%
	Home health services—nursing services	8	0.6%	2,401	2,386	0	2,386	0.2%
	Home health services—aide services	6	0.4%	427	427	0	427	0.0%
	Home health services—supplies	19	1.4%	3,810	3,656	0	3,656	0.3%
15	Lab and x-ray	52	3.8%	1,198	578	3	575	0.0%
16	Prescribed drugs	257	19.0%	26,778	26,772	0	26,772	1.9%
19	Other services—prosthetic devices	3	0.2%	364	288	0	288	0.0%
	Other services—Home and Community-Based Services waiver	208	15.3%	346,023	332,720	96	332,624	23.2%
20	Capitated care[1]	2	0.1%	2,675	2,675	0	2,675	0.2%
21		42	3.1%	1,786	1,653	49	1,604	0.1%
26	Transportation	72	5.3%	16,621	8,739	170	8,569	0.6%
30	Personal care services	34	2.5%	4,870	4,497	0	4,497	0.3%
31	Targeted case management services	27	2.0%	5,104	4,781	0	4,781	0.3%
33	Rehabilitative services	18	1.3%	447	412	0	412	0.0%
34	Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders	4	0.3%	14,943	10,524	0	10,524	0.7%
35	Hospice services	1	0.1%	2	2	0	2	0.0%
37	Nurse practitioner	2	0.1%	450	278	0	278	0.0%
38	Private-duty nurse	**1,356**	**99.8%[2]**	**$1,792,017**	**$1,443,161**	**$11,132**	**$1,432,029**	**99.8%[2]**
	Total							

[1] This category encompasses capitated payments to two Medicaid Statistical Information System (MSIS) codes: 20—Health Maintenance Organization and Health Insuring Organization and 21—Prepaid Health Plans. We used the broad title of "Capitated care" because we could not determine which errors related to which MSIS codes.

[2] Total does not equal 100 percent due to rounding.

APPENDIX D: SUMMARY OF CLASSIFIABLE DATA PROCESSING ERRORS AND THE RESULTING OVERPAYMENTS AND UNDERPAYMENTS FOR EACH TYPE

	MSIS Numerical Codes and Definitions	Number of Errors	Percentage of Errors	Total Payment for Sample Items With Errors	Amount of Overpayment	Amount of Underpayment	Net Overpayment Amount	Percentage of Net Overpayment
1	Inpatient hospital	32	15.8%	$239,151	$27,897	$20,418	$7,479	7.0%
2	Mental hospital services for the aged	1	0.5%	9,900	9,900	0	9,900	9.2%
4	Inpatient psychiatric under 21	1	0.5%	312	312	0	312	0.3%
5	Intermediate care facility for mentally retarded	6	3.0%	43,385	10,236	0	10,236	9.5%
7	Nursing facility	30	14.9%	105,901	59,300	372	58,928	54.9%
8	Physician	17	8.4%	18,463	11,372	20	11,352	10.6%
9	Dental	2	1.0%	195	0	82	(82)	-0.1%
11	Outpatient hospital	17	8.4%	23,321	2,879	638	2,241	2.1%
12	Clinic services	11	5.4%	1,184	534	39	495	0.5%
13	Home health services—supplies	4	2.0%	77	14	142	(128)	-0.1%
14	Crossover claims	4	2.0%	1,170	1,105	0	1,105	1.0%
15	Lab and x-ray	11	5.4%	914	39	7	32	0.0%
16	Prescribed drugs	23	11.4%	214,594	709	230	479	0.4%
19	Other services—Home and Community-Based Services waiver	3	1.5%	7,233	224	888	(664)	-0.6%
20 21	Capitated care[1]	28	13.9%	11,324	6,528	1,965	4,563	4.3%
22	Capitated payments primary care case management	1	0.5%	2	0	0	0	0.0%
92	Part B premium[2]	10	5.0%	1,149	1,060	0	1,060	1.0%
93	Health insurance premium[3]	1	0.5%	237	0	0	0	0.0%
	Total	**202**	**100.1%[4]**	**$678,512**	**$132,109**	**$24,801**	**$107,308**	**100%**

[1] This category encompasses capitated payments to two MSIS codes: 20—Health Maintenance Organization and Health Insuring Organization and 21—Prepaid Health Plans. We used the broad title of "Capitated care" because we could not determine which errors related to which MSIS code.

[2] There is no official MSIS category for Part B premiums. However, in a Centers for Medicare & Medicaid Services (CMS) letter addressed to the States selected for 2006 PERM program reviews, the States were instructed to use this code.

[3] There is no official MSIS category for health insurance premiums. However, in a CMS letter addressed to the States selected for 2006 PERM program reviews, the States were instructed to use this code.

[4] Total does not equal 100 percent due to rounding.

APPENDIX E: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 0 2 2010

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Analysis of Improper Payments Identified During the Payment Error Rate Measurement Program Reviews in 2006 and 2007" (A-06-09-00079)

Thank you for the opportunity to comment on the OIG draft report entitled, "Analysis of Improper Payments Identified During the Payment Error Rate Measurement (PERM) Program Reviews in 2006 and 2007" (A-06-09-00079). We appreciate the OIG's review of the errors identified during the 2006 and 2007 PERM processes. CMS developed the PERM program to comply with the Improper Payments Improvement Act of 2002 (IPIA) and the Office of Management and Budget's requirement to measure improper payments in the Medicaid program.

An integral part of the PERM process is to estimate improper payments, as well as assist States in reducing their improper payments and maintaining the fiscal integrity of the Medicaid program. The OIG's additional analysis demonstrates the utility of using PERM data to focus on high-dollar errors by service type and error type so States can target their corrective actions and improve the accuracy of their payments. We believe that completing and sharing this additional analysis with States will strengthen the outcome of the PERM process and enable States to better focus their corrective actions to reduce improper payments as we move forward.

We appreciate the OIG's work in this area and look forward to working with them as we refine the PERM process. Our response to the OIG's recommendation is below.

OIG Recommendation

For future PERM years, we recommend that CMS develop and provide to the States analytical data similar to that contained in this report and encourage the States to use the data to help ensure that payments, including those funded by the Recovery Act, comply with Federal requirements.

CMS Response

CMS concurs and will implement the recommendation starting with the FY 2010 measurement cycle.

To implement this recommendation, CMS will:

- Perform an analysis similar to the OIG's, categorizing errors by service type and error type, and circulate this analysis to all States for each PERM year;
- In conjunction with the PERM Technical Advisory Group, solicit the States for other useful categories or data analysis techniques that might be instrumental in reducing improper Medicaid payments;
- Incorporate these analyses in the corrective action efforts that CMS and States implement; and
- Track and report these analyses over time to monitor the effectiveness of the resulting error reduction efforts.

Again, we believe providing this additional data will strengthen the PERM measurement and assist the States in identifying specific areas that present financial risk to the Medicaid program.