March 2, 2010

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of California's Department of Health Care Services Fiscal Year 2007 Payment Error Rate Measurement Universes (A-06-08-00050)

The attached final report provides the results of our review of California's Department of Health Care Services (DHCS) fiscal year (FY) 2007 Payment Error Rate Measurement (PERM) universes, as required by the Improper Payments Information Act of 2002 (IPIA), P.L. No. 107-300. The Centers for Medicare & Medicaid Services (CMS) developed the PERM program (1) to comply with the IPIA and Office of Management and Budget (OMB) requirements for measuring improper Medicaid program and State Children's Health Insurance Program (SCHIP) payments made in Medicaid's fee-for-service (FFS) component in FY 2006 and (2) to measure improper payments made in the FFS, managed care, and eligibility components of Medicaid and SCHIP in FY 2007 and future years. OMB requires CMS to include the PERM results in its annual accountability report.

States are required to submit quarterly a list of beneficiary-specific claims (universe) to the statistical contractor. Each State should submit a maximum of four universes per quarter, one for each program area the State operates. From each of the quarterly universes, the statistical contractor selects a sample for review.

Our objectives were to determine (1) whether DHCS's PERM managed care and FFS universes were complete and accurate and could be reconciled to the Federal reimbursement reported on the Forms CMS-64 and CMS-21 and (2) the extent to which CMS staff reconciled the Forms CMS-64 and CMS-21 to detailed claim information.

DHCS was unable to reconcile the PERM universes to the quarterly Forms CMS-64 and CMS-21. We could not determine whether DHCS's managed care and FFS universes were complete and accurate. We were unable to reconcile the managed care and FFS universes to the Forms CMS-64 and CMS-21.

CMS Regional Office officials stated that they had performed a reconciliation of the Forms CMS-64 and CMS-21 to the accounting records that DHCS used to support the Forms CMS-64

and CMS-21. However, those accounting records did not include the detailed claim information. DHCS officials stated that they could not reconcile the Forms CMS-64 and CMS-21 to the managed care or FFS universes, and the California State Auditor found that the Form CMS-64 was not traceable to individual claims.

We recommend that CMS:

- instruct DHCS to reconcile its PERM universes to the Forms CMS-64 and CMS-21 it submits to CMS and ensure that its universes are complete and accurate,

- instruct DHCS to implement a payment system that produces information that is readily available, and

- include steps in the California Financial Management Review to annually reconcile various expenditures on the Forms CMS-64 and CMS-21 to detailed claim information.

In its comments on our draft report, CMS did not agree to implement our first two recommendations and did not specifically address our third recommendation. CMS stated that reconciling the Forms CMS-64 and CMS-21 to the PERM universes is problematic because of timing and offered alternatives to a complete reconciliation. CMS agreed that a new payment system for DHCS is necessary but said implementation was dependent on the availability of State budget resources to support the change. CMS did not specifically address our recommendation to include steps in the Financial Management Review to annually reconcile various expenditures on the Forms CMS-64 and CMS-21 to detailed claim information.

Without reconciling the PERM universe to the Forms CMS-64 and CMS-21, CMS is unable to show that it has complied with the requirements of OMB Circular A-123, Appendix C, to produce a statistically valid estimate of improper payments. While we recognize that California budgetary resources are at a premium, it is essential to the integrity of the Medicaid program that the Forms CMS-64 and CMS-21 be readily traceable to detailed claims information. The reconciliation of the Forms CMS-64 and CMS-21 to detailed claim information must be part of the Financial Management Review to help ensure States are submitting valid claims.

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

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph J. Green, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through email at Joe.Green@oig.hhs.gov. Please refer to report number A-06-08-00050 in all correspondence.

Attachment

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CALIFORNIA'S DEPARTMENT OF HEALTH CARE SERVICES FISCAL YEAR 2007 PAYMENT ERROR RATE MEASUREMENT UNIVERSES

Daniel R. Levinson
Inspector General

March 2010
A-06-08-00050

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

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

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and OMB requirements for measuring improper Medicaid program and State Children's Health Insurance Program (SCHIP, now known as CHIP) payments. CMS intended for the PERM program to measure improper payments made in Medicaid's fee-for-service (FFS) component in fiscal year (FY) 2006 and to measure improper payments made in the FFS, managed care, and eligibility components of Medicaid and SCHIP in FY 2007 and future years.

States are required to submit quarterly a list of beneficiary-specific claims (universe) to the statistical contractor. Each State should submit a maximum of four universes per quarter, one for each program area the State operates. From each of the quarterly universes, the statistical contractor selects a sample for review.

California's Department of Health Care Services (DHCS) FFS system processes and pays claims at the individual claim level. Managed care payments are lump-sum payments to the managed care plans. These payments are based on groupings of the managed care enrollees identified in DHCS's eligibility system. DHCS multiplies the members in each cohort by their capitation rate to determine the total amount paid to the managed care plan.

Because DHCS does not create or record beneficiary-specific managed care payment records in its payment system, the statistical contractor needed an alternate approach to review DHCS's managed care payments for the PERM program. As a result, DHCS officials created a pseudo universe by creating a payment record for each managed care beneficiary member-month based on the beneficiary's rate category. This universe was not based on the actual payments that were processed through the State's claims-processing system.

Amounts reported on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (Form CMS-64) and the "Quarterly State Children's Health Insurance Program Statement of Expenditures for Title XXI" (Form CMS-21) must be actual expenditures. The information for Forms CMS-64 and CMS-21 expenditures is obtained from sources such as invoices, cost reports, and eligibility records. When claims are developed through the use of estimating techniques, they are considered estimates and are not to be reported on Forms CMS-64 and CMS-21.

The CMS Regional Office conducts quarterly reviews of the Forms CMS-64 and CMS-21. During these reviews, CMS Regional Office staff reconcile the amounts reported to the accounting records the State used to support the Forms CMS-64 and CMS-21. Additional procedures are performed in accordance with the requirements of the CMS review guides. The California State Auditor also conducts reviews of the Form CMS-64.

OBJECTIVES

Our objectives were to determine:

- whether DHCS's PERM managed care and FFS universes were complete and accurate and could be reconciled to the Federal reimbursement reported on the Forms CMS-64 and CMS-21 and

- the extent to which CMS staff reconciled the Forms CMS-64 and CMS-21 to detailed claim information.

SUMMARY OF FINDING

DHCS was unable to reconcile the PERM universes to the quarterly Forms CMS-64 and CMS-21. We could not determine whether DHCS's managed care and FFS universes were complete and accurate. We were unable to reconcile the managed care and FFS universes to the Forms CMS-64 and CMS-21.

CMS Regional Office officials stated that they performed a reconciliation of the Forms CMS-64 and CMS-21 to the accounting records that DHCS used to support the Forms CMS-64 and CMS-21. However, those accounting records did not include the detailed claim information. DHCS officials stated that they could not reconcile the Forms CMS-64 and CMS-21 to the managed care or FFS universes, and the California State Auditor found that the Form CMS-64 was not traceable to individual claims.

RECOMMENDATIONS

We recommend that CMS:

- instruct DHCS to reconcile its PERM universes to the Forms CMS-64 and CMS-21 it submits to CMS and ensure that its universes are complete and accurate,

- instruct DHCS to implement a payment system that produces information that is readily available, and

- include steps in the California Financial Management Review to annually reconcile various expenditures on the Forms CMS-64 and CMS-21 to detailed claim information.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

CMS did not agree to implement our first two recommendations. CMS did not specifically address our third recommendation.

Regarding our first recommendation, CMS said that "obtaining the final expenditure data in time to complete all reviews and calculations before the November 15 error rate reporting due date is problematic" and offered alternatives to a complete reconciliation of the PERM sampling universe to the Medicaid and SCHIP claims data (CMS-64 and CMS-21). CMS agreed in principle with our second recommendation but said implementation was dependent on the availability of State budget resources to support the change. CMS did not specifically address our recommendation to include steps in the Financial Management Review to annually reconcile various expenditures on the Forms CMS-64 and CMS-21 to detailed claim information.

CMS's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Without reconciling the PERM universes to the Forms CMS-64 and CMS-21, CMS is unable to show that it has complied with the requirements of OMB Circular A-123, Appendix C, for "a statistically valid estimate of the annual amount of improper payments . . . ." The results obtained from statistical sampling of the PERM universe are applicable only to the universe from which the sample was drawn. Therefore, if the PERM universe differs from the States' actual Medicaid and SCHIP claims included on the Forms CMS-64 and CMS-21, States are determining the error rate in the PERM universe, not necessarily the error rate in the Medicaid and SCHIP programs.

We recognize that State budgetary resources are at a premium. However, it is essential to the integrity of the Medicaid and SCHIP programs that the Forms CMS-64 and CMS-21 be readily traceable to detailed claims information.

The reconciliation of Forms CMS-64 and CMS-21 to detailed claim information must be part of the Financial Management Review to help ensure California is submitting valid claims.

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INTRODUCTION

BACKGROUND

Improper Payments Information Act of 2002

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

Improper Payments Information Act of 2002 Implementation Guidance

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

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

OMB identified the Medicaid program and the State Children's Health Insurance Program (SCHIP)[1] as programs at risk for significant erroneous payments. OMB requires the Department of Health and Human Services (HHS) to report the estimated amount of improper payments for each program annually in its accountability report. For example, the amount of fiscal year (FY) 2007 improper payments was reported in the HHS "FY 2008 Agency Financial Report," dated November 17, 2008.

Payment Error Rate Measurement Program

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and OMB requirements for measuring improper Medicaid and SCHIP payments. CMS intended for the PERM program to measure improper payments made in Medicaid's fee-for-service (FFS) component in FY 2006 and to measure improper payments made in the FFS, managed care, and eligibility components of Medicaid and SCHIP in FY 2007 and future years.

[1]As a result of the Children's Health Insurance Program Reauthorization Act of 2009, P.L. No. 111-3, this program is now referred to as the Children's Health Insurance Program. Because our findings relate to FY 2007, we use "SCHIP" throughout the report.

States are required to submit quarterly a list of beneficiary-specific claims (universe) to the statistical contractor. Each State should submit a maximum of four universes per quarter, one for each program area the State operates. The statistical contractor selects a sample for review from each of the quarterly universes.

California Department of Health Services' Managed Care System

The California Department of Health Care Services (DHCS) does not create or record beneficiary-specific managed care payment records in its payment system. Instead, all plan payments are made through a process that begins with a summarized managed care plan enrollment report from California's eligibility system. DHCS manually transfers the report into plan-specific spreadsheets containing capitation rates that are based on groupings of individuals called cohorts. DHCS then multiplies the members in each cohort by the applicable capitation rate and calculates the total payment due. Because DHCS does not create or record beneficiary-specific managed care payment records in its payment system, the statistical contractor needed an alternate approach to review DHCS's managed care payments for the PERM program. As a result, DHCS officials created pseudo universes using the following method:

- accessing monthly copies of the Medicaid and SCHIP eligibility system, archived on the 15th of each month;

- identifying who on that date each month was recorded in the eligibility system as enrolled in a health maintenance organization (HMO) and what his or her rate category was; and

- creating a pseudo payment record for each HMO member-month with the data fields required for the PERM managed care universes.

California Department of Health Services' Fee-for-Service System

The DHCS FFS payment system processes and pays claims at the individual claim level. DHCS developed its FFS universe by querying the payment system for claims that met the PERM requirements. After DHCS compiled the paid claims, it had to add claims to the universe, such as denied claims and claims under $0.50, because these claims were not in the payment system but were required to be part of the PERM universe. DHCS accumulates paid claims records from all payment sources in its paid claims system. The contractor that processes claims for DHCS provided the additional claims.

Forms CMS-64 and CMS-21 Reporting Requirements

The CMS "State Medicaid Manual," chapter 2, section 2500, says that the amounts reported on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (Form CMS-64) must be actual expenditures for which all supporting documentation must be in readily reviewable form. The information for Form CMS-64 expenditures is obtained from sources such as invoices, cost reports, and eligibility records. When claims are developed through the use of estimating techniques, they are considered estimates and are not to be reported on a Form CMS-64.

CMS guidance on the "Quarterly State Children's Health Insurance Program Statement of Expenditures for Title XXI" (Form CMS-21) states the same requirements.

Centers for Medicare & Medicaid Services Oversight

The CMS Regional Office conducts quarterly reviews of the Forms CMS-64 and CMS-21. During these reviews, CMS Regional Office staff reconciles the amounts reported on the Forms CMS-64 and CMS-21 to the accounting records the State used to support the Forms CMS-64 and CMS-21. Additional procedures are performed in accordance with the requirements of the appropriate CMS review guide. The CMS Regional Office staff follows the CMS "Financial Review Guide for the Quarterly Medicaid Statement of Expenditures" to conduct the Form CMS-64 review and the "Financial Review Guide for the Quarterly State Children's Health Insurance Program Statement of Expenditures for Title XXI" to conduct the Form CMS-21 review. In this report, we will refer to these documents as the "CMS review guides."

If CMS identifies an area during the quarterly reviews as a risk area, it performs a Financial Management Review. These reviews are focused reviews and cover the identified risk areas. CMS develops a review guide for each risk area that is approved for review.

California State Auditor

The Bureau of State Audits reviewed and reported on California's internal controls and compliance with California and Federal laws and regulations. DHCS is included in this review. For the years ended June 30, 2006 and 2007, the California State Auditor determined that the Form CMS-64 was not traceable to individual claims and recommended that DHCS implement an audit trail so funding sources for individual claims can be identified.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine:

- whether DHCS's PERM managed care and FFS universes were complete and accurate and could be reconciled to the Federal reimbursement reported on the Forms CMS-64 and CMS-21 and

- the extent to which CMS staff reconciled the Forms CMS-64 and CMS-21 to detailed claim information.

Scope

We reviewed the first and fourth quarters of FY 2007 PERM universes submitted by DHCS to the statistical contractor.

We did not review the statistical contractor's overall internal control structure because the audit objectives did not require it.

We performed fieldwork at the statistical contractor in Falls Church, Virginia, and DHCS in Sacramento, California, from April through June 2008.

Methodology

To accomplish our objectives, we:

- met with officials at the CMS Central Office, the statistical contractor, and DHCS to understand how DHCS compiled the pseudo managed care universes and the FFS universes;

- met with DHCS officials to obtain an understanding of the PERM process at the State level;

- judgmentally selected the first and fourth quarters of DHCS's FY 2007 pseudo managed care and FFS universes and reviewed them at DHCS;

- attempted to reconcile DHCS's Forms CMS-64 and CMS-21 to DHCS's pseudo managed care and FFS universes for the first and fourth quarters of FY 2007;

- met with CMS Regional Office officials to obtain an understanding of CMS's oversight performed on the Forms CMS-64 and CMS-21; and

- reviewed the California State Auditor reports for 2006 and 2007 for conditions related to the Forms CMS-64 and CMS-21.

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 finding and conclusions based on our audit objectives.

FINDING AND RECOMMENDATIONS

DHCS was unable to reconcile the PERM universes to the quarterly Forms CMS-64 and CMS-21. Without such a reconciliation, we could not determine whether DHCS's pseudo managed care and FFS universes were complete and accurate. We were unable to reconcile the PERM pseudo managed care and FFS universes to the Forms CMS-64 and CMS-21.

CMS Regional Office officials stated that they performed a reconciliation of the Forms CMS-64 and CMS-21 to the accounting records that DHCS used to support the Forms CMS-64 and CMS-21 in accordance with the CMS review guides. However, those accounting records did not include the detailed claim information. DHCS officials stated that they could not reconcile the

Forms CMS-64 and CMS-21 to the PERM pseudo managed care or FFS universes, and the California State Auditor found that the Form CMS-64 was not traceable to individual claims.

POTENTIALLY INACCURATE AND INCOMPLETE STATE UNIVERSES

Managed Care Universes

The statistical contractor selected samples of beneficiary-level enrolled months from the PERM pseudo managed care universes that may not have been complete and accurate. The PERM program does not require the statistical contractor or the States to reconcile the State universes of claims to any financial reports. Likewise, the statistical contractor's quality assurance procedures do not require reconciling the State universes to financial reports. Therefore, CMS has no assurance that the DHCS's universes are complete and accurate.

We also attempted to reconcile DHCS's pseudo managed care universes of FY 2007 first and fourth quarter claims to DHCS's Forms CMS-64 and CMS-21 but were unable to do so. Although we discussed our attempted reconciliation with DHCS officials and they provided additional information, we still were unable to reconcile DHCS's Forms CMS-64 and CMS-21 data to the universes. The differences we identified during the reconciliation process are shown in Table 1.

Table 1: Managed Care Amounts Reported for the Payment Error Rate Measurement and on the Forms CMS-64 and CMS-21 for Federal Fiscal Year 2007

	Medicaid Managed Care 1st Quarter	Medicaid Managed Care 4th Quarter	SCHIP Managed Care Expansion[2] 1st Quarter	SCHIP Managed Care Expansion[2] 4th Quarter
PERM	$1,448,771,326	$1,420,127,478	$18,931,146	$22,382,705
Forms CMS-64 and CMS-21	$1,313,701,427	$1,506,585,807	$24,808,695	$32,421,040
Difference	$135,069,899	($86,458,329)	($5,877,549)	($10,038,335)
Difference as a percentage of amount on the Forms CMS-64 and CMS-21	10.3%	(5.7%)	(23.7%)	(31.0%)

[2]When developing its SCHIP program, each State has the option of making SCHIP part of an expanded Medicaid program, a separate program, or a combination of both. California chose a combined approach in which it expanded its Medicaid program and contracted with a third party to manage part of SCHIP. This report addresses only DHCS's portion of SCHIP.

We discussed the pseudo managed care universes with DHCS officials to determine whether there was an alternate approach to verify the completeness and accuracy of the pseudo managed care universes. For various reasons, alternative approaches were not practical. According to a DHCS official, attempting to look at every California beneficiary enrolled in a managed care program would require reviewing more than 8 million records. Additionally, DHCS pays the monthly capitation payments to the managed care plans in a lump-sum payment. There is no documentation attached to this payment that identifies the beneficiaries that the payment covers, and DHCS relies on the plans to inform DHCS if the payments are incorrect.

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

Fee-for-Service Universes

The statistical contractor selected FFS samples of adjudicated claims from DHCS universes that may not have been complete and accurate. We attempted to verify the completeness and accuracy of DHCS's FFS universes of FY 2007 first and fourth quarter claims by reconciling them to the DHCS's Forms CMS-64 and CMS-21 but were unable to do so. Although we discussed our reconciliation with DHCS officials and they provided additional information, we still were unable to reconcile DHCS's Forms CMS-64 and CMS-21 data to its PERM FFS universes. The differences we identified during the reconciliation process are shown in Table 2.

Table 2: Fee-for-Service Amounts Reported for the Payment Error Rate Measurement and on the Forms CMS-64 and CMS-21 for Federal Fiscal Year 2007

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

The statistical contractor provided instructions to the States regarding which payments to include in their State universes. According to a CMS-approved letter from the statistical contractor to State health officials containing claims data submission instructions for the FY 2007 PERM, the PERM universe consisted of all adjudicated FFS Medicaid and SCHIP claims that were originally paid or denied payment from October 1, 2006, through September 30, 2007, and that involved Federal financial participation. Thus the PERM universe should have included all Medicaid and SCHIP FFS payments, including those processed outside of the States' payment systems. The PERM universe also should have included claims for which the States had no additional liability to pay, for example, a claim for which a third party was liable or a Medicare payment that exceeded the States' allowable charges. Because we were not able to reconcile DHCS's PERM FFS universes to the Forms CMS-64 and CMS-21, we could not determine whether all required claims were included in the universes.

Centers for Medicare & Medicaid Services Oversight

CMS officials informed us that their review of the Forms CMS-64 and CMS-21 is done in accordance with the CMS review guides. According to a CMS official, CMS can expand or curtail its testing and review procedures depending on the complexity of a State's program and issues identified during the review process. CMS officials informed us that they reconciled the Forms CMS-64 and CMS-21 to the accounting records that DHCS used to support the Forms CMS-64 and CMS-21. However, the accounting records that DHCS used to support the Forms CMS-64 and CMS-21 did not include the detailed claim information. DHCS officials informed us that the detailed claim information was not readily available.

California State Audit Reports

The California State Auditor found that DHCS's Form CMS-64 was not traceable to individual claims and recommended that DHCS implement an audit trail so that funding sources for individual claims can be identified. The California State Auditor reported this finding in consecutive years. DHCS agreed with the finding and stated that the system was to be redesigned by January 2009 with the capability to trace summary reports to individual claims.

RECOMMENDATIONS

We recommend that CMS:

- instruct DHCS to reconcile its PERM universes to the Forms CMS-64 and CMS-21 it submits to CMS and ensure that its universes are complete and accurate,

- instruct DHCS to implement a payment system that produces information that is readily available, and

- include steps in the California Financial Management Review to annually reconcile various expenditures on the Forms CMS-64 and CMS-21 to detailed claim information.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS did not agree to implement our first two recommendations. CMS did not specifically address our third recommendation. CMS's comments are summarized below and included in their entirety as the Appendix.

Reconciling Payment Error Rate Measurement Universes to Forms CMS-64 and CMS-21

Centers for Medicare & Medicaid Services Comments

CMS explained that "obtaining the final expenditure data in time to complete all reviews and calculations before the November 15 error rate reporting due date is problematic." Instead of reconciling the current quarter, CMS is requiring States to compare their quarterly PERM universes to Forms CMS-64 and CMS-21 from the two previous quarters to ensure that all required programs from all necessary data sources are included in the PERM universes. Then, as part of its data quality control process, the statistical contractor reconciles each State's quarterly universe to that quarter's Forms CMS-64 and CMS-21 and, for each quarter, follows up with the States to account for variances over 15 percent. After universe submissions are complete, the statistical contractor follows up with the CMS Regional Offices and the States to account for variances between PERM universes and Forms CMS-64 and CMS-21 of more than 5 percent.

Office of Inspector General Response

CMS did not specifically address our recommendation as it relates to DHCS. While CMS has implemented a reconciliation process with the statistical contractor, reconciling within 5 percent is not sufficient to meet the statistical requirements of OMB Circular A-123, Appendix C. Without reconciling the PERM universes to the Forms CMS-64 and CMS-21, CMS is unable to show that it has complied with the requirements of OMB Circular A-123, Appendix C, for "a statistically valid estimate of the annual amount of improper payments . . . ."

The results obtained from statistical sampling of the PERM universe are applicable only to the universe from which the sample was drawn. Therefore, if the PERM universe differs from the States' actual Medicaid and SCHIP claims included on the Forms CMS-64 and CMS-21, States are determining the error rate in the PERM universe, not necessarily the error rate in the Medicaid and SCHIP programs.

Implementing a Payment System That Produces Readily Available Information

Centers for Medicare & Medicaid Services Comments

CMS agreed in principle that all States should produce audit trails and other payment information that is timely and accurate. Historically, California has had no automated link between its accounting system and its claims-processing system. CMS stated that DHCS has submitted a Systems Development Notice to redesign the system to provide an automated link.

However, implementing the change is "subject to the availability of State budget resources … to support the change."

Office of Inspector General Response

We recognize that State budgetary resources are at a premium. However, it is essential to the integrity of the Medicaid and SCHIP programs that the Forms CMS-64 and CMS-21 be readily traceable to detailed claims information.

Reconciling Expenditures on the Forms CMS-64 and CMS-21 Periodically

Centers for Medicare & Medicaid Services Comments

CMS did not specifically address our recommendation to include steps in the Financial Management Review to annually reconcile various expenditures on the Forms CMS-64 and CMS-21 to detailed claim information. However, CMS agreed that Federal claims should be periodically reconciled to claims information.

Office of Inspector General Response

The reconciliation of Forms CMS-64 and CMS-21 to detailed claim information must be part of the Financial Management Review to help ensure California is submitting valid claims.

APPENDIX

APPENDIX: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG 20 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of California's Department of Health Care Services Fiscal Year 2007 Payment Error Rate Measurement Universes" (A-06-08-00050)

Thank you for the opportunity to comment on the OIG draft report entitled, "Review of California's Department of Health Care Services Fiscal Year 2007 Payment Error Rate Measurement Universes." We appreciate the OIG's review of California's reconciliation processes. We have reviewed the report and have responded to your recommendations.

OIG Recommendation

Instruct the Department of Health Care Services (DHCS) to reconcile its Payment Error Rate Measurement (PERM) universes to the Forms CMS-64 and CMS-21 it submits to CMS and ensure that its universes are complete and accurate.

CMS Response

The Centers for Medicare & Medicaid Services (CMS) implemented a reconciliation process beginning with the Medicaid and Children's Health Insurance Program (CHIP) universe submissions for the fiscal year (FY) 2008 PERM cycle. The States submitted universes and CMS' statistical contractor validated the universes for completeness and accuracy through comparison with Financial Management Reports. The statistical contractor followed up with the CMS Regional Offices and the States to account for any variances between PERM universes and Financial Reports over 5 percent.

Beginning with the FY 2009 PERM cycle, CMS is requiring States, including California, to compare their PERM universes to the two previous quarters' Forms CMS-64 and CMS-21. The purpose of this comparison is for States to ensure they are submitting all required programs from all necessary data sources in their PERM universes. Then, as part of its data quality control process, the statistical contractor reconciles each quarterly universe to that quarter's Forms CMS-64 and CMS-21. For each quarter, the statistical contractor follows up with States to

account for variances over 15 percent. After universe submissions are complete, the statistical contractor follows up with the CMS Regional Offices and the States to account for variances between PERM universes and Forms CMS-64 and CMS-21 over 5 percent.

As we have discussed, obtaining the final expenditure data in time to complete all reviews and calculations before the November 15 error rate reporting due date is problematic. We will of course continue to work with the OIG to refine the estimation and reconciliation process that will result in a more accurate calculation.

OIG Recommendation

Instruct DHCS to implement a payment system that produces information that is readily available.

CMS Response

We agree that all States should produce audit trails and other payment information that is both timely and accurate. With regard to California, there has been no historical automated link between the California State Accounting and Reporting System and the State's Medicaid Management Information System (MMIS) claims processing system. Instead, whenever reconciliation to individual claims is required, the State has to run ad-hoc reports out of its MMIS system to determine the individual claims that were combined to arrive at a particular expenditure report summary. While audit trails exist, they are slow and cumbersome to reproduce.

The State Agency has informed CMS staff that a Systems Development Notice has been submitted to redesign the system to provide an automated capability to trace summary reports to claims-level data. The change will be designed and implemented by the State's MMIS contractor but that change is subject to the availability of State budget resources being made available to support the change.

OIG Recommendation

Include steps in the California Financial Management Review to annually reconcile various expenditures on the Forms CMS-64 and CMS-21 to detailed claim information.

CMS Response

We agree it is imperative that Federal claims be periodically reconciled to claims information.

The CMS utilizes National Review Guides to conduct desk reviews and on-site reviews of CMS-64 and CMS-21 quarterly expenditure reports. Integral to those reviews are steps to reconcile Federal claims back to State accounting and other supporting records. Relative risk of specific line items is assessed in part through variance analysis and other analytical techniques. Investigation of aberrant claim amounts can result in drilling down to claims-level data as needed.

Additionally, the CMS Regional Offices conduct focused financial management reviews each year on targeted program areas in most States. When provider claims are reviewed, the scope and coverage generally involves reconciling to and sampling individual provider claims.