

The Payment Error Rate Measurement Program Snapshot

The Improper Payments Information Act of 2002 (IPIA) and the Improper Payments Elimination and Recovery Improvement Act of 2012[1] require all Federal agencies to review their programs and activities to identify those subject to significant improper payments. The agencies are required to estimate the amount of improper payments and submit an annual report to Congress on those estimates and the actions they are taking to reduce them.[2] IPIA defines “improper payment” as “any payment that should not have been made or that was made in an incorrect amount.”[3]

To better meet the requirements of IPIA, the Centers for Medicare & Medicaid Services (CMS) adopted regulations establishing the Payment Error Rate Measurement (PERM) program. Under this program, CMS requires State Medicaid agencies (SMAs) to provide the information necessary for estimating improper payments and determining error rates. The necessary information may relate to policies, contracts, data processing system manuals, appeals, or adjustments.[4] CMS does not require this information from every SMA every year. Instead, it has divided the States into three groups with staggered reporting dates, and each group reports every 3 years.[5]

CMS uses a statistical contractor to check the quality of the information gathered from States, draw a sample, and format the details. CMS’ review contractor then reviews and processes the claims information. CMS also requires Medicaid fee-for-service and the Children’s Health Insurance Program (CHIP) providers to submit medical records to validate the beneficiary claims billed within 75 days of request.[6]

After the statistical information is gathered and medical reviews are completed, the statistical contractor analyzes the results, calculates error rates, prepares a final report, and provides an analysis for corrective action.[7] CMS reviews the report and determines the amount of overpayments resulting from medical and processing errors. CMS then ensures that SMAs return the Federal share of the overpayments.[8, 9]

Each SMA must analyze the causes of error and develop a corrective action plan to reduce improper payments.[10] Corrective action plans can include training and revision of manuals,[11] imposition of pre-authorization requirements,[12] or pre-payment screening of claims. More information about corrective action plans can be found in the E-Bulletin, “Corrective Actions to Prevent Improper Payments Snapshot,” which is posted to the Medicaid Program Integrity Education page at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/ebulletins.html> on the CMS website.

For More Information

To view the electronic version of this and other E-Bulletins and for more information on other program integrity topics posted to the Medicaid Program Integrity Education page, visit <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website.

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References

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