CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Payment Error Rate Measurement (PERM)

Introduction to PERM

October 2012

Centers for Medicare & Medicaid Services

Agenda

- History and overview
- Methodology
- Roles and responsibilities
- Differences between FY2010 and FY2013 cycles
- FY2013 process details
- Best Practices
- Communication and collaboration
- Contact information

History and Overview

Voluntary and Pilot Measurement of Payment Error Rates in Medicaid and CHIP

- Prior to FY 2001 there was no systematic means to measure improper payments in Medicaid or CHIP at the national level
  - Administration of Medicaid and CHIP varies significantly at the state level
  - Some states routinely measured payment accuracy but did not use a methodology that allowed national error rate calculation
- From FY 2002 – FY 2004 CMS sponsored the voluntary Payment Accuracy Measurement (PAM) pilot
  - Tested and refined methodologies to measure payment accuracy rate in fee-for-service (FFS), managed care, and eligibility

Initial Development of the National Payment Error Rate Measurement (PERM) Program

- In 2002 Congress enacted the Improper Payments Information Act of 2002 (IPIA)
  - Medicaid and CHIP identified as susceptible programs
- In FY 2006, CMS implemented the PERM methodology to estimate improper payments in FFS Medicaid
  - Began a 17-state rotation for PERM (each state is reviewed once every three years)
  - Began reporting a national error rate for Medicaid for each federal fiscal year

Expansion and Refinement of the PERM Program

- In FY 2007 CMS expanded the methodology to measure the accuracy of Medicaid managed care payments, CHIP FFS and managed care payments, and Medicaid and CHIP eligibility decisions
- In 2009 Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - Required changes to the PERM methodology
  - Postponed CHIP measurement until new rules could be issued
- New PERM regulation, effective September 10, 2010, creates differences between FY 2010 and FY 2013

Continuing Evolution of the PERM Program

- IPIA was amended by the Improper Payments Elimination and Recovery Act (IPERA) in 2010
  - Reaffirmed necessity of PERM measurement and required additional “supplemental” measures for vulnerable programs

PERM Methodology Overview

Measuring Payment Errors in Medicaid and CHIP

- Goal of PERM is to measure and report an unbiased estimate of the true error rate for Medicaid and CHIP
- Because it is impossible to verify the accuracy of every Medicaid and CHIP payment, CMS uses a statistically valid methodology that samples a small subset of payments and then extrapolates to the “universe” of payments

Sampling Overview

- PERM uses a two-stage sampling approach
  - Sample a subset of states (small, medium, and large) from among the 51 state programs
  - From within each state, select a random sample of payments and select a random sample of eligibility decisions
  - Review the payments and eligibility decisions for errors
  - Use the findings to extrapolate a national error rate
- A national error rate can be extrapolated from a subset of 17 states
  - CMS could randomly sample 17 states each year, but chose to use a 17-state rotation (each state is reviewed every three years)

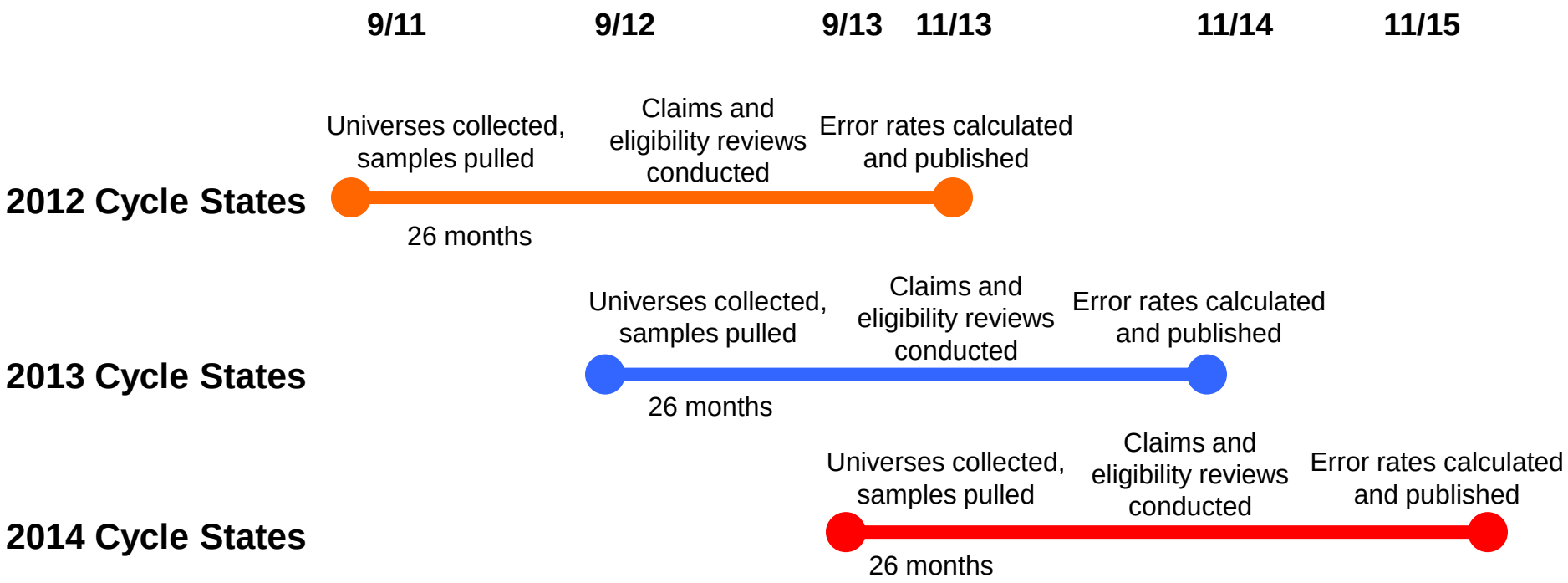
PERM State Rotation

Cycle	Medicaid and CHIP States Measured by Cycle
Cycle 1	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 3	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

PERM Cycle Progression

- Process of sampling and reviewing payments and calculating and reporting error rates takes more than two years
  - Payments and eligibility decisions for an entire fiscal year are collected
  - Payments and eligibility decisions are reviewed
  - Findings are used to calculate error rates

PERM Cycle Progression



Roles and Responsibilities

PERM Roles and Responsibilities

- Several organizations are involved in the PERM measurement:
  - CMS
  - States
  - Statistical Contractor
  - Review Contractor

CMS PERM Team Responsibilities

- Structure the parameters for measurement through legal and policy decision-making processes
- Oversee the operation of PERM and PERM contractors to ensure that CMS meets its regulatory requirements
- Provide guidance and technical assistance to states throughout the process
- Ensure measurement remains on track and work with states when challenges occur

CMS PERM Team Responsibilities

- Host monthly cycle calls
- Review state-requested appeals of error findings
- Provide educational resources for Medicaid and CHIP providers
- Provide assistance as states develop corrective actions
- Ensure improper payments are recovered

State Responsibilities

- Provide a representative to spearhead PERM
- Provide claims data to Statistical Contractor
- Educate providers on PERM process and assist with medical record collection
- Assisting Review contractor with accessing state policies for review
- Assist Review Contractor with on-site and/or remote data processing reviews
- Request difference resolution/appeals for differences and re-price partial errors
- Conduct eligibility reviews and report findings to CMS
- Participate in cycle calls with CMS
- Develop and implement corrective actions to reduce improper payments
- Return FFP of Fee-for-service and managed care overpayments

Statistical Contractor Responsibilities

- Conducts orientation/intake with each state
- Collects FFS and managed care universe data from states
- Performs quality control procedures to assure accurate and complete universes
- Selects random samples from the universes on a quarterly basis
- Requests details from the states for sampled FFS claims
- Maps data to a standard format
- Delivers samples and details to Review Contractor

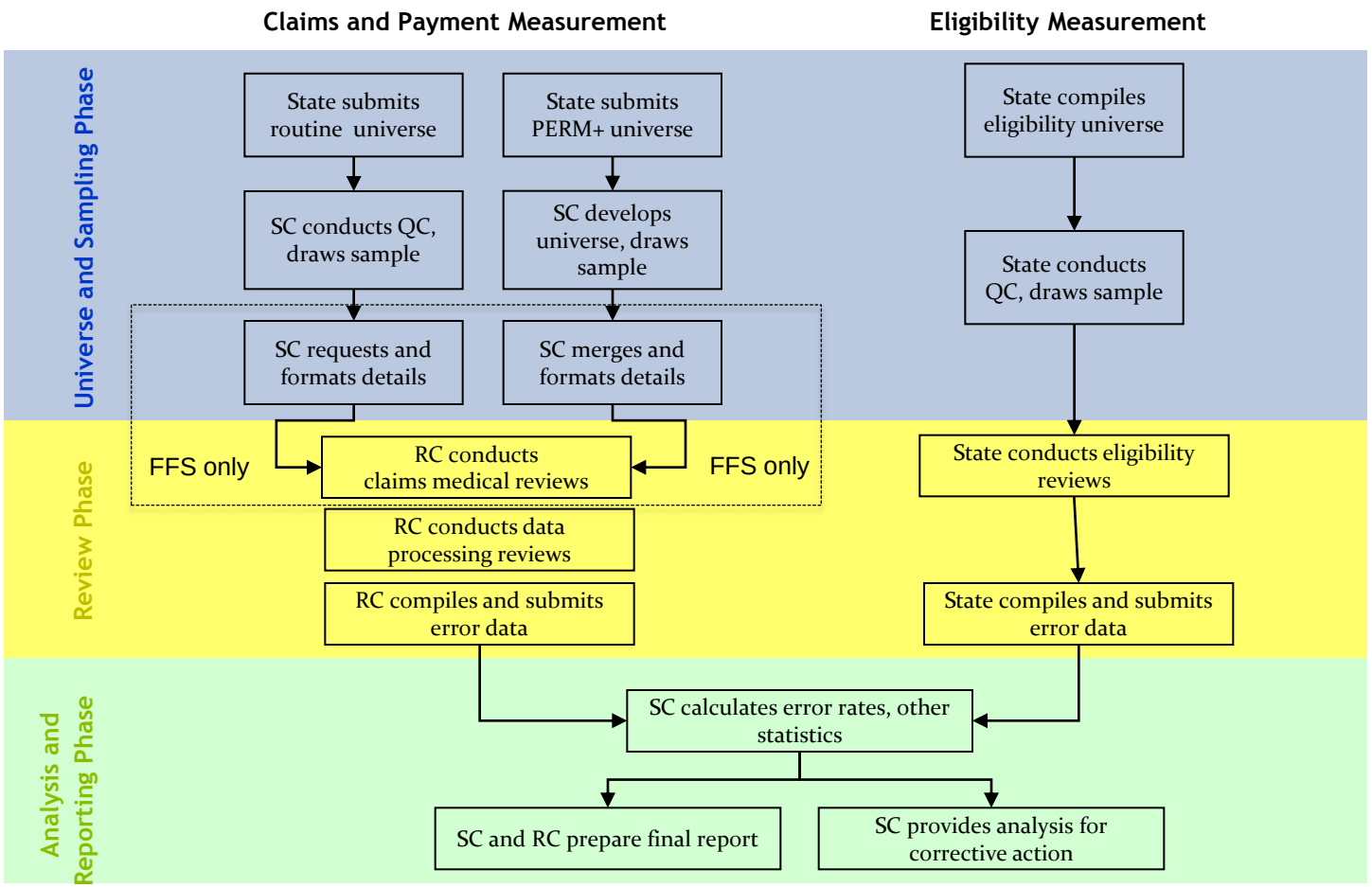
Statistical Contractor Responsibilities

- Reviews and approves states' eligibility sampling plans
- Maintains eligibility website to collect eligibility findings from states
- Calculates the component (FFS, managed care, eligibility), state and national error rates for Medicaid and CHIP
- Conducts analysis for corrective action
- Assists in preparing final report

Review Contractor Responsibilities

- Research, collect, and request Medicaid and CHIP state policies including program information, fee schedules, systems, and billing manuals
- Requests medical records from providers
- Conduct data processing and medical review orientations for each State
- Conducts data processing reviews on all sampled payments
- Conducts medical/coding reviews on relevant sampled FFS payments
- Maintains the SMERF website with a state portal to track activities and findings
- Reviews and responds to requests for difference resolution
- Notifies States of final overpayment errors for recovery purposes
- Assists in preparing final report

PERM Cycle Progression



Differences Between FY2010 and FY2013 Cycles

Differences between FY 2010 and FY 2013 PERM Cycles

FFY 2010	FFY 2013
Only Medicaid measured	Both Medicaid and CHIP measured
PERM Contractors: •SC – Livanta •RC – A+	PERM Contractors: •SC – The Lewin Group •RC – A+
One submission timeline for FFS and Managed Care universe data	States can submit Q1 Managed Care data with Q2 universe submission
Stratification by dollar value for FFS sampling	Stratification by service type for FFS sampling

Differences between FY 2010 and FY 2013 PERM Cycles

FFY 2010	FFY 2013
States had to break aggregate payments into beneficiary-specific records for submission	States may be able to submit some aggregate payments in their aggregate form
One data submission method for all states	Two data submission methods – states can either submit data using the new PERM+ process or continue routine PERM submission
Same FFS and managed care sample sizes for all states	State-specific Medicaid sample sizes for each component; Base sample sizes for CHIP

Differences between FY 2010 and FY 2013 PERM Cycles

FFY 2010	FFY 2013
No option for electronic submission of medical records for providers	Providers may submit medical records electronically through the esMD program
4 Provider Education Conference Calls	Monthly interactive Provider Education Webinars
PERT Eligibility Website	PETT Eligibility Website
No requirement for Eligibility Category and Cause of Error was not standardized	Standardized drop down boxes for Eligibility Category Fields and Cause of Error fields

Differences between FY 2010 and FY 2013 PERM Cycles

FFY 2010	FFY 2013
Eligibility universes must be stratified into three strata	PERM stratification is optional

Process Details

Statistical Contractor: Universe Collection and Sampling

- PERM independently samples payments from four universes or program areas
  - Medicaid FFS
  - CHIP FFS
  - Medicaid managed care
  - CHIP managed care
- In FY13, each program area is divided into strata based on service type

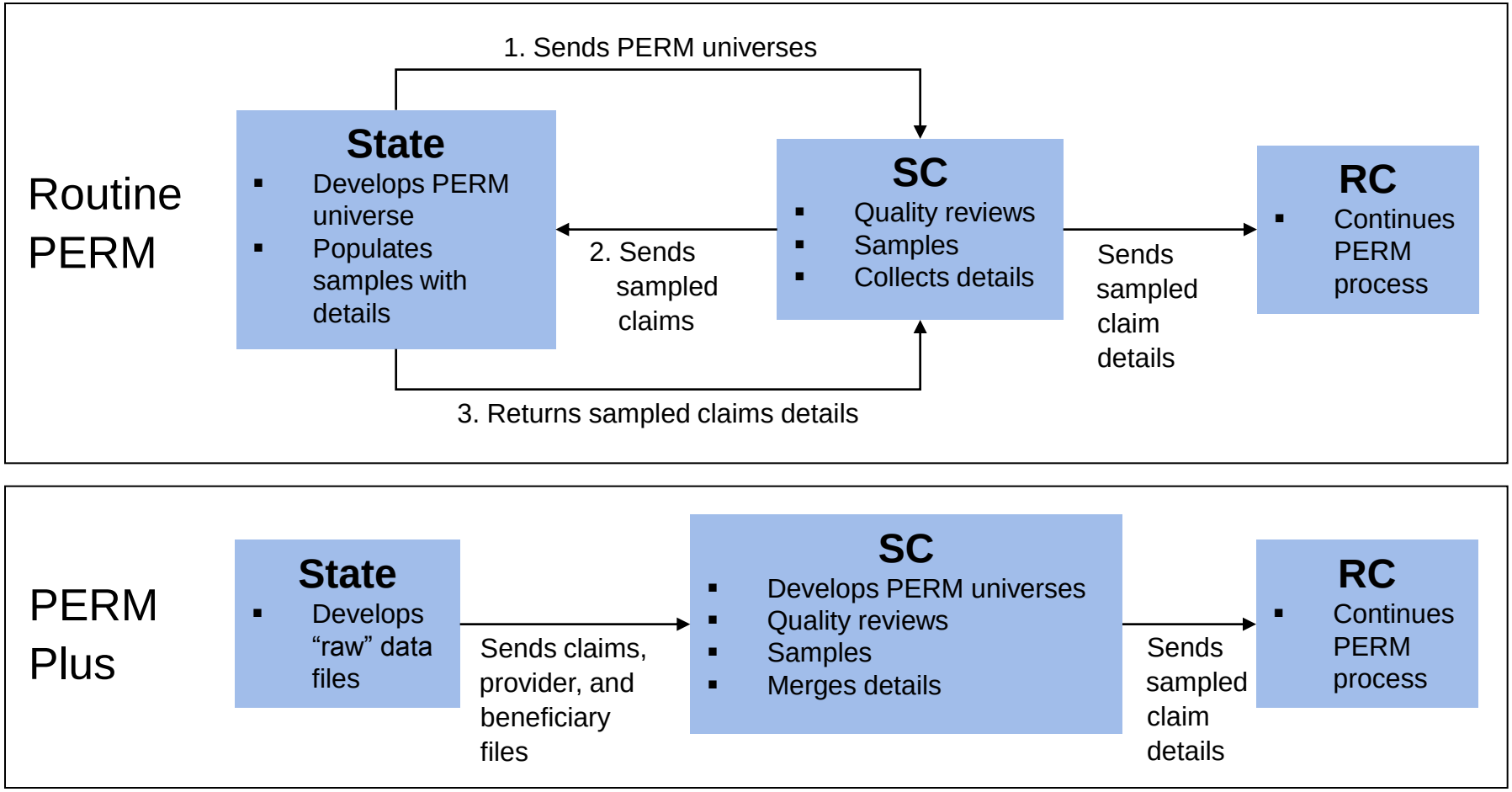
Statistical Contractor: Universe Collection

- PERM universe contains essentially all Medicaid and CHIP service payments that are fully adjudicated by the state each quarter
  - Includes individual claims, capitation payments and payments processed outside of MMIS or made in aggregate for multiple services
  - Excludes claim adjustments, administrative costs, state-only expenditures and certain payments as defined in regulation
- Some fields (e.g., date paid, amount paid) have PERM-specific definitions that are important for consistency

Statistical Contractor: State-Specific Sample Sizes

- The Statistical Contractor will calculate state-specific sample sizes for each claims component for each state
  - FFS
  - Managed care
- Because Cycle 2 did not have a CHIP measurement in FY10, the base sample sizes will apply
  - 520 claims for FFS
  - 250 claims for managed care
- The only exceptions are the States which opted to accept their FY07 CHIP error rates.

Statistical Contractor: Universe Collection and Sampling



Statistical Contractor: Error Rate Calculation

- For each state, error rates are estimated for Medicaid and CHIP
  - Payment error rates, based on a sample of claims
    - If a state has both FFS and managed care, separate payment error rates are estimated, then weighted together according to expenditures
  - Eligibility error rates, based on a sample of cases
- For each program (Medicaid and CHIP) a combined error rate is estimated that combines the FFS and managed care payment rates with the eligibility rate for the program

Review Contractor: Collection of State Policies

- Initial request call and follow up letter
  - Initial request to schedule medical review orientation call and follow up notice
  - Download Policies from State websites (as much as possible)
  - Can also accept by fax or hard copy
  - Review policy questionnaire and identify outstanding policies needed during MR orientation call
  - Establish policy contacts with participating States
  - Confirmation by State of Master Policy List
  - Policy abstraction and storage to document management system
- Quarterly updates

Review Contractor: Medical Record Requests

- Uses provider information from data files submitted by states
- Initial call to provider to verify provider information
  - State support needed for incorrect/non-current contact information
- Initial request packet sent to provider
  - CMS letter (with authority to request records)
  - PERM fax cover sheet with specific documentation request list for each claim category sampled
  - Claim summary data provided for specific claim sampled
  - Instructions for record submission methods

Review Contractor: Medical Record Requests

- Providers have 75 calendar days to send in medical records
  - RC will follow-up with reminder calls and letters at 30 days, 45 days and 60 days, if not submitted
  - 75 day non-response letter (MR1 error) sent to providers and copied to States in weekly batches, if record not submitted
- Insufficient documentation - Providers have 14 calendar days to send in documentation
  - Specific detail provided verbally and in writing for missing documentation – reminder calls and letters at 7 days
  - 15 day non-response letter (MR2 error) sent to providers and copied to States in weekly batches, if record not submitted

Review Contractor: DP Review

- Completed on all sampled claims
  - Validation review of system processing
- Entrance Interview/Orientation
  - Scheduled as soon as possible after sample received from SC
  - Provide overview of PERM processes
  - Work with States for DP staff education/systems overview and demonstration
  - RC IT staff will work with states to establish secure access to individual state systems (remote)
  - Collection of all State program information, systems, and billing manuals needed for DP review
  - Establish state contacts, working protocols and start dates for reviews

Review Contractor: DP Review

- DP FFS review components include comparison against applicable state policy for:
  - Claims submission (verification of recipient information, TPL and provider eligibility)
  - Accurate payments:
    - Duplicate claims
    - Covered services
    - System edits
    - Claims filing deadlines
    - Pricing/reimbursement methodology
    - Adjustments made within 60 days of paid date

Review Contractor: Medical/Coding Reviews

- FFS claims only (excludes denials, Medicare Part A and B premium payments, Primary Care Case Management payments)
- Basic components include:
  - Reviewing sampled units from RC website
  - Electronic access to collected and stored records
  - Determine sufficiency of documentation submitted

Review Contractor: Medical/Coding Reviews

- Six primary elements in medical/coding reviews:
  - Adherence to State specific guidelines and policies
  - Completeness of medical documentation
  - Medical necessity determined based on documentation
  - Validation that services were ordered
  - Validation that services were provided as billed
  - Correct coding based on documentation submitted

Review Contractor: RC Website

- Tracks all sampled unit workload, receipt of medical records, reviews, and final results
- Provides real-time information on status of record requests and receipts; progress of reviews for both DP and medical reviews
- State's access includes ability to create and/or download reports, file for Difference Resolution and CMS appeals, and access Final Error For Recovery Reports for recovery of overpayment errors
- Training and access provided during the month when reviews begin
- Access limited to states, contractors and CMS through password protection

Eligibility Review Process

- States complete the eligibility sampling component of the PERM process and conduct eligibility reviews
- Each program (Medicaid and CHIP) submits an eligibility sampling plan to the SC for review
- States sample cases, review eligibility status, collect payments associated with the cases in the sample month
- States complete reporting forms on sampling progress
- SC calculates three eligibility error rates (active case rate, negative case rate, payment error rate)

Eligibility Review Process

- Revised eligibility instructions on CMS website
- Relevant changes:
  - Section related to CHIPRA
  - Exclusion of Express Lane Eligibility Cases
  - Guidance on MEQC data substitution
  - Expanded acceptable self declaration and introduced guidance on passive renewal
- Sampling plans were due August 1, 2012

Eligibility Review Process

- First monthly sample submission due November 15th
- Orientation to PERM eligibility reporting website will be held prior to the November 15th submission deadline

Best Practices

Best Practices – Statistical Contractor

- Check FTP compatibility before submitting the Q1 data
  - this includes encrypting, password-protecting, and uploading file
- Keep a list of all data sources and ensure that data from all sources is included in the state's transmission each quarter
- Include subject matter experts as part of the PERM team early in the cycle to gain clear understanding of data submission instructions and PERM requirements

Best Practices – Review Contractor

- Allocate resources to PERM throughout the Cycle at each phase of the project
- Correct any issues identified from last PERM measurement Cycle
- If state routinely purges claims:
  - Have the purge process held until after PERM reviews, or
  - if already purged prior to sampling, identify all purged sampled claims and have full claim re-populated in system prior to start of DP reviews.

Best Practices – Review Contractor

- Keep provider licensing information updated in MMIS system
- Update provider contacts in MMIS for claims sampled for PERM before State submits quarterly detail data to the SC
- Tracks all medical record requests in SMERF to assure providers timely responses
- Contact providers on all non-response error letters (MR1s and MR2s)

Communication and Collaboration

Communication and Collaboration

- Cycle calls
  - Scheduled for the fourth Thursday of every month 2:00-3:00 PM EDT
- CMS PERM website
  - http://www.cms.gov/PERM
- Technical Advisory Group (TAG)
  - Quarterly TAG calls as a forum to discuss PERM policy issues and recommendations to improve the program
  - Regional TAG Reps

CMS Contact Information

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