

Payment Error Rate Measurement Manual

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10. Payment Error Rate Measurement Program Introduction

10.1 Overview of the Payment Error Rate Measurement Program

The purpose of the Payment Error Rate Measurement (PERM) program is to produce a national-level error rate for Medicaid and the Children’s Health Insurance Program (CHIP) in order to comply with the requirements of the Improper Payments Elimination and Recovery Improvement Act (IPERIA) (2012).

10.2 PERM Legislative Background

The Improper Payments Information Act of 2002 (IPIA) Pub. L. 107–300, enacted on November 26, 2002, required the heads of Federal agencies annually to review programs they oversee that are susceptible to significant erroneous payments. The IPIA directed the Office of Management and Budget (OMB) to provide guidance on implementation. OMB defined “significant erroneous payments” as annual erroneous payments in the program exceeding both 2.5 percent of program payments and \$10 million (OMB M–03–13, May 21, 2003 and OMB M–06–23, August 10, 2006).

According to the OMB directive, Federal agencies must report to the President and Congress: (1) the estimate of the annual amount of erroneous payments; (2) a discussion of the causes of the errors and actions taken to correct those problems, including plans to increase agency accountability; (3) a discussion of the amount of actual erroneous payments the agency expects to recover; (4) limitations that prevent the agency from reducing the erroneous payment levels, that is, resources or legal barriers; and (5) a target for the program’s future payment rate, if applicable.

The Medicaid and CHIP programs were identified by OMB as programs at risk for significant erroneous payments. OMB directed the Department of Health and Human Services (DHHS) to report the estimated error rates for the Medicaid and CHIP programs each year for inclusion in the Agency Financial Report (AFR). Through the Payment Accuracy Measurement (PAM) and PERM pilot projects that Centers for Medicare and Medicaid (CMS) operated in Fiscal Years (FYs) 2002 through 2005, we developed a claims-based review methodology designed to estimate State-specific payment error rates for all adjudicated claims within 3 percent of the true population error rate with 95 percent confidence. An “adjudicated claim” is a claim for which either money was obligated to pay the claim (paid claims) or for which a decision was made to deny the claim (denied claims).

The IPIA was amended on July 10, 2010, by the Improper Payments Elimination and Recovery Act (IPERA), Pub. L. 111-204. IPERA requires agencies to conduct annual risk assessments, and if a program is found to be susceptible to significant improper payments, agencies must measure improper payments in that program.

IPERA was further amended on January 10, 2013, by the Improper Payments Elimination and Recovery Improvement Act (IPERIA), Pub. L. 112-248. The aim of IPERIA is to further emphasize the importance of not only identifying and recovering improper payments but also to conduct the necessary analyses to reduce improper payments.

10.3 CMS Rulemaking

Section 1102(a) of the Social Security Act (the Act) authorizes the Secretary to establish such rules and regulations as may be necessary for the efficient administration of the Medicaid and CHIP programs. The Medicaid statute at section 1902(a) (6) of the Act and the CHIP statute at section 2107(b) (1) of the Act require States to provide information that the Secretary finds necessary for the administration, evaluation, and verification of the States' programs. Also, section 1902(a) (27) of the Act (and 42 CFR 457.950) requires providers to submit information regarding payments and claims as requested by the Secretary, State agency, or both.

Under the authority of these statutory provisions, CMS published a proposed rule on August 27, 2004 (69 FR 52620) to comply with the requirements of the IPIA and the OMB guidance. Based on the methodology developed in the PAM and PERM pilot projects, the proposed rule set forth provisions for all States annually to estimate improper payments in their Medicaid and CHIP programs and to report the State-specific error rates for purposes of computing the national improper payment estimates for these programs. The intended effects of the proposed rule were to have States measure improper payments based on Fee-For-Service (FFS), managed care, and eligibility reviews; to identify errors; to target corrective actions; to reduce the rate of improper payments; and to produce a corresponding increase in program savings at both the State and Federal levels.

After extensive analysis of the issues related to having States measure improper payments in Medicaid and CHIP, including public comments on the provisions in the proposed rule, CMS revised its approach. CMS adopted the recommendation to engage Federal contractors to review State Medicaid and CHIP FFS and managed care claims and to calculate the State-specific and national error rates for Medicaid and CHIP. Based on these rates, the Federal contractor will calculate the national eligibility error rate for each program. CMS also adopted the recommendation to sample a subset of States each year rather than to measure every State every year. CMS adopted these recommendations primarily in response to commenters' concerns with the cost and burden to implement the regulatory provisions at the State level that the proposed rule would have imposed on States.

Since CMS' revised approach departed significantly from the approach in the proposed rule, CMS published an interim final rule with comment period on October 5, 2005 (70 FR 58260). The October 5, 2005 interim final rule with comment period responded to the public comments on the proposed rule, and informed the public of the national contracting strategy and of the plan to measure improper payments in a subset of States. A State will be measured once, and only once, every 3 years for each program. For each fiscal year, CMS stated that it expected to measure up to 18 States.

In the October 5, 2005 interim final rule, CMS stated that it was still possible that States sampled for review would be required to conduct eligibility reviews as described in the proposed rule. CMS also announced its intentions to establish an eligibility workgroup to make recommendations on the best approach for reviewing Medicaid and CHIP eligibility within the confines of current statute, with minimal impact on States and additional discretionary funding. CMS convened an eligibility workgroup comprised of DHHS (including CMS and, in an advisory capacity, the Office of the Inspector General (OIG)), OMB, and representatives from

two States. CMS determined that States should conduct the eligibility measurement and developed an eligibility measurement methodology based on the workgroup's consideration of public comments, the examination of various approaches proposed in such comments, and the suggestions of the panel members. The October 5, 2005 interim final rule also set forth the types of information that States would submit to the Federal contractors for the purpose of estimating Medicaid and CHIP FFS improper payments and invited further comments on methods for estimating eligibility and managed care improper payments. CMS received very few comments regarding managed care and a number of comments regarding eligibility.

Based on the public comments and recommendations from the eligibility workgroup, CMS published a second interim final rule on August 28, 2006 (71 FR 51050), which set forth the methodology for measuring improper payments in Medicaid and CHIP FFS, managed care, and eligibility in 17 States per cycle and invited further public comments on the eligibility measurement. CMS implemented the PERM program in a final rule published on August 31, 2007 (72 FR 50490). The August 31, 2007 final rule responded to the public comments on the August 28, 2006 interim final rule and finalized State requirements for submitting claims to the Federal contractors that conduct FFS and managed care reviews. The final rule also finalized State requirements for conducting eligibility reviews and estimating payment error rates due to errors in eligibility determinations.

On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) was enacted. Sections 203 and 601 of the CHIPRA relate to the PERM and Medicaid Eligibility Quality Control (MEQC) programs. Section 203 of the CHIPRA establishes an error rate measurement with respect to the enrollment of children under the Express Lane Eligibility option. The law directs States not to include children enrolled using the Express Lane Eligibility option in data or samples used for purposes of complying with the MEQC and PERM requirements.

Section 601(a) of the CHIPRA provides for a 90 percent Federal match for CHIP expenditures related to PERM administration and excludes such expenditures from the 10 percent administrative cap. (Section 2105(c)(2) of the CHIP statute gives States the ability to use an amount up to 10 percent of the CHIP benefit expenditures for outreach efforts, additional services other than the standard benefit package for low-income children, and administrative costs.) The CHIPRA requires a new PERM rule and delays any calculation of a PERM error rate for CHIP until 6 months after the new PERM rule is effective. The CHIPRA requires that the new PERM rule include the following:

- Clearly defined criteria for errors for both States and providers
- Clearly defined processes for appealing error determinations
- Clearly defined responsibilities and deadlines for States in implementing any corrective action plans
- A provision that the payment error rate for a State will not include payment errors based on a State's verification of an applicant's self-declaration if a State's self-declaration verification policies meet regulations promulgated by the Secretary or is approved by the Secretary
- State-specific sample sizes for application of the PERM requirements to CHIP PERM

In addition, the CHIPRA shall harmonize the PERM and MEQC programs and provide States with the option to apply PERM data from eligibility reviews to meet MEQC requirements and vice versa, with certain conditions.

As required by the CHIPRA, CMS proposed revised MEQC and PERM provisions in the proposed rule published in the July 15, 2009 Federal Register (74 FR 34468). CMS implemented a revised program through a final PERM rule published on August 11, 2010 (75 FR 48815). In addition to the provisions required by CHIPRA, the new rule addresses the claims universe, sampling and review; the eligibility universe, sampling and review; error determination and rate calculation; difference resolution and appeals; and corrective action.

After CHIPRA, the Patient Protection and Affordable Care Act (PPACA) of 2010, more commonly known as the Affordable Care Act (ACA), was enacted, resulting in significant changes to the Medicaid and CHIP programs which have had a direct impact on PERM.

Due to the implementation of the ACA, the Data Processing Review process has expanded to assure State compliance with new provider enrollment and risk based screening requirements. To verify that the provider(s), including billing, attending/servicing, and ordering/referring providers per 42 CFR 455.410, were registered and eligible to provide services as well as refer and bill for the services under review, the following provider information is reviewed:

- Provider name
- Provider number (42 CFR 455.440 National Provider Identifier)
- Provider registration/enrollment (42 CFR 455.410)
- Provider license, if required (42 CFR 455.412)
- CLIA certification, if required
- Provider type and specialty
- Provider and service location
- Provider sanction/suspension periods, including verifying a provider is not listed on the OIG's List of Excluded Individuals/Entities (LEIE)

The risk-based screening process, which is required for newly enrolled providers after March 24, 2011 is as follows:

- Verify whether a risk level was assessed in accordance with the levels assigned by Medicare for the same provider types from the provider file in MMIS (may not be assessed a lower level than assigned by Medicare)
- Request verification of the risk level assigned from the State if the screening is not in the State system
- Verify whether the provider was screened by Medicare using CMS' Provider Enrollment, Chain and Ownership System (PECOS) to determine whether that screening was conducted and enrollment approved prior to the claim under review, if the State is unable to provide proof of compliance

In light of the changes to the way States adjudicate eligibility for applicants for Medicaid and CHIP implemented by ACA, the State Health Official Letter 13-005 issued on August 15, 2013 directs States to implement Medicaid and CHIP Eligibility Review Pilots in place of the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) eligibility review requirements for fiscal years (FY) 2014-2016.¹ CMS has subsequently recommended an extension of these pilots for an additional year, so that the PERM eligibility component will re-start in FY 2018. The Medicaid and CHIP Eligibility Review Pilots will provide more targeted, detailed information on the accuracy of eligibility determinations using ACA's rules, and provide States and CMS with critical feedback during initial implementation.

The eligibility review pilots will provide a testing ground for different approaches and methodologies for producing reliable results and help inform CMS's approach to rulemaking that it will undertake prior to the resumption of PERM eligibility measurement component in FY 2018. In general, under these Medicaid and CHIP Eligibility Review Pilots:

- All states will participate annually as a means to ensure that there are no gaps in oversight during this transition period.
- States will be conducting four streamlined pilot measurements over the three year period and results will be reported to CMS in June 2014, December 2014, June 2015 and June 2016.
- States will submit project descriptions and sampling approaches to CMS for expedited approval as directed in CMS guidance.

10.4 Definitions

Active fraud investigation: A beneficiary or a provider has been referred to the State Medicaid Fraud Control Unit or similar Federal or State investigative entity including a Federal oversight agency and the unit is currently actively pursuing an investigation to determine whether the beneficiary or the provider committed health care fraud. This definition applies to both the claims and eligibility.

Adjudicated claim: In reference to denied claims, an adjudicated claim is one that has been accepted and reviewed by the claim processing system and the decision to deny the claim has been made. In reference to paid claims, an adjudicated claim refers to a submitted claim that has been accepted and fully reviewed and a positive determination has been made regarding the payment amount. For denied claims, the adjudication date should be used to determine whether a claim is included in a fiscal quarter if the State system does not capture a "paid date" for these claims. For paid claims, the date paid should be used for this determination.

Adjustment: Change to a previously submitted claim that is linked to the original claim.

Annual sample size: The number of fee-for-service claims, managed care payments, or eligibility cases necessary to meet precision requirements in a given PERM cycle.

¹ Guidance related to the FY 2014-2016 eligibility pilots can be found on the CMS PERM website: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html.

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

Children’s Health Insurance Program (CHIP): A program authorized and funded under Title XXI of the Social Security Act. Federal regulations governing this program are at 42 CFR Part 457.

CHIP universe (Claims): Claims and payments where all services are paid with Title XXI funds, including Title XXI Medicaid expansion claims and payments (where beneficiaries are enrolled in Medicaid, but their claims and payments are matched with Title XXI funding) that are funded under CHIP.

Claim: A request for payment, on either an approved form or electronic media, for services rendered generally relating to the care and treatment of a disease or injury or for preventative care. A claim may consist of one or several line items or services.

Denied claim or line item: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment and not approved for payment in whole or in part.

Difference resolution: A process that allows States to dispute the Review Contractor’s (RC’s) error findings.

Encounter data: Encounter data or “shadow claims” are defined as informational-only records submitted to a State by a provider or MCO for services covered under a managed care capitation payment. These data are often collected by a State in order to track utilization, assess access to care, and possibly compute risk adjustment factors for at-risk managed care contractors, but are not claims submitted for payment.

Eligibility: Meeting the State’s categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs.

Fee-for-service (FFS): A traditional method of paying for medical services under which providers are paid for each service rendered.

FFS processing error: A payment error that can be determined from the information available from the claim or from other information available in the State Medicaid/CHIP system (exclusive of medical reviews and eligibility reviews).

Finite Population Correction (FPC) factor: A statistical calculation that may be employed by the State or the Statistical Contractor (SC) to determine sample sizes as an alternative to the base rates when sampling programs in which the total (full year) sample is drawn from a population of less than 10,000 individuals/claims.

Health Insurance Premium Payment (HIPP) program: A program allowing States to choose to have Medicaid or CHIP pay beneficiaries’ private health insurance premiums when it is more cost-effective than paying for the full cost of Medicaid or CHIP services.

Improper payment: Any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible beneficiary, any duplicate payment, any payment for services not received, any payment incorrectly denied, and any payment that does not account for credits or applicable discounts.

Individual reinsurance: In the context of PERM managed care universe files, individual reinsurance payments are those payments made by the State to a managed care plan for an individual beneficiary whose cost of care has exceeded a predetermined maximum amount, usually measured on an annual basis or on the basis of a specific episode of care. Such payment by the State typically represents a cost sharing arrangement with a managed care plan for extremely high-cost enrollees. Individual reinsurance may be based on the costs associated with all services provided by the managed care plan, or may be limited to excessive costs associated with certain services (e.g., transplants). (Note: providers whose payment rates are fully reconciled for actual costs incurred, on a retrospective basis, are considered to be FFS.)

Kick payment: Supplemental payment over and above the capitation payment made to managed care plans for beneficiaries utilizing a specified set of services or having a certain condition.

Line item: An individually-priced service presented on a claim for payment. Items individually listed but priced in a bundled service rather than being priced individually are not considered “line items.”

Managed care: A system where the State contracts with health plans, on a prospective full-risk or partial-risk basis, to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered.

Managed care organization (MCO): An entity that has entered into a risk contract, with a State Medicaid and/or CHIP agency, to provide a specified package of benefits to Medicaid and/or CHIP enrollees. The MCO assumes financial responsibility for services delivered and is responsible for contracting with and reimbursing servicing providers. State payments to MCOs are typically done on the basis of a monthly capitation payment per enrolled beneficiary.

Medicaid: A joint Federal and State program, authorized under Title XIX of the Social Security Act (the Act) that provides medical care to people with low incomes and limited resources.

Medicaid universe (Claims): Claims and Payments where all services are paid with Title XIX funds.

Medicaid Statistical Information System (MSIS): The MSIS, housed by CMS, collects statistical data from each of the States on an annual basis (using form HCFA-2082). The system includes aggregated statistical data on beneficiaries, services, and expenditures during a Federal fiscal year (i.e., October 1 through September 30).

Medical review error: An error that is determined from a review of the medical documentation in conjunction with State medical policies and information presented on the claim.

Medicare: The federal health insurance program for people 65 years of age or older and certain younger people with disabilities or End Stage Renal Disease. Beneficiaries must pay (or have paid on their behalf) premiums for the two main portions of Medicare: Part A (hospital) and Part B (physician) services. There are also two optional Medicare parts: Part C (managed care) and Part D (prescription drug coverage).

Non-claims based sampling unit: Sampling units that are not related to a particular service provided, such as Medicare Part A or Part B premiums.

Overpayment: Overpayments occur when the State pays more than the amount the provider was entitled to receive or paid more than its share of the cost.

Paid claim: A claim or line item that was accepted by the claims processing or payment system, adjudicated for payment, determined to be a covered service eligible for payment, and for which a payment was issued or no payment was due to circumstances such as payment by a third party insurer.

Partial error: Partial errors are those that affect only a portion of the payment on a claim.

Patient liability: The term used by the Medicaid program to refer to the amount for covered services paid by the Medicaid beneficiary.

Payment: Any payment to a provider, insurer, or managed care organization for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP FFP. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulations or policy.

Payment error rate: An annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

PERM Website: The official CMS website for the PERM program located at <http://www.cms.gov/PERM>.

PERM+: A claims and payment data submission method where the State submits claims, provider, and beneficiary data to the SC. The SC uses the data to build universes from which a random sample of claims is selected. After drawing the samples, the SC sends the samples to the RC and the States. The SC then populates the sampled FFS claims with detailed service and payment information and sends these samples to the RC.

Primary Care Case Management (PCCM): A program in which beneficiaries are linked to a primary care provider who coordinates their health care. Providers receive small additional payments to compensate for care management responsibilities, typically on a per member per month basis. Providers are not at financial risk for the services they provide or authorize.

Program of All-inclusive Care for the Elderly (PACE): A benefit that States may at their option offer to Medicaid beneficiaries age 55 or older who have been determined to require the level of care provided by a nursing facility. Qualifying beneficiaries receive all Medicaid-

covered services through the PACE provider in which they enroll. PACE providers must meet minimum federal standards and are paid on a capitation basis.

Provider error: This includes, but is not limited to, medical review errors as described in 42 CFR 431.960(c), as determined in accordance with documented State or Federal policies or both.

Recipient: An applicant for, or recipient of, Medicaid or CHIP program benefits.

Risk-based managed care: The MCO assumes either partial or full financial risk, and is paid a fixed monthly premium per beneficiary.

Routine PERM: A claims and payment data submission method where the State submits claims universes to the SC. The SC draws a random sample of claims from the quarterly universes submitted by the State. After drawing the samples, the SC sends the samples to the RC. The SC also sends the States a list of their sampled claims, and States populate sampled FFS claims with detailed service and payment information for the SC. The SC formats the State submissions and sends them to the RC.

Sample: A random sample of claims selected from a universe (see “universe” definition below).

Sampling unit: The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, a month of enrollment in a managed care plan or a monthly Medicare premium). Depending on the universe (e.g., fee-for-service or managed care), the sampling unit includes: claim, line item, premium payment, or capitation payment

State error: This includes, but is not limited to, data processing errors and eligibility errors as described in 42 CFR 431.960(b) and (d), as determined in accordance with documented State or Federal policies or both.

Stop-loss: See “Individual Reinsurance,” above.

Supplemental payments for specific services or events: These are payments, often called “kick” payments that may be made by the State to a managed care organization on behalf of a particular enrollee in the managed care plan, based on the provision of a particular service or the occurrence of a particular event, such as childbirth.

Third party liability (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. In cases of available TPL, Medicaid is payer of last resort.

Underpayment: Underpayments occur when the State pays less than the amount the provider was entitled to receive or less than its share of cost.

Universe (Claims): The universe is the set of sampling units from which the sample for a particular program area is drawn and the set of payments for which the error rate is inferred from the sample. The term “claim” is used interchangeably with the term “sampling unit.”

Zero-paid claim: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and approved for payment, but for which the actual amount remitted was zero dollars. This can occur due to third-party liability, application of deductibles and patient liability, or other causes.

10.5 PERM Partners and Their Responsibilities

CMS contracts with two vendors to conduct the fee-for-service and managed care components of the PERM measurement, and to calculate error rates: a Statistical Contractor (SC) and a Review Contractor (RC).

The SC responsibilities include:

- Conducting Intake Meetings with State staff prior to each cycle to collect relevant information about systems, programs, and payment methodologies
- Collecting quarterly fee-for-service (FFS) claims and managed care capitation payment universes from each State
- Conducting extensive quality control review checks on each submitted universe, including comparing PERM universe data to State-submitted CMS-64 and CMS-21 reports
- Selecting quarterly random samples from each submitted universe for review by the RC
- Calculating State and national error rates
- Creating error analysis reports used by States for corrective action purposes
- Maintaining the PERM Eligibility Tracking Tool (PETT) 2.0 which States use to report FY14-18 pilot proposals and findings
- Supporting CMS in the review of State-submitted FY14-18 pilot proposals and findings

The RC responsibilities include:

- Researching, requesting, and collecting applicable Federal Regulations under 42 CFR and State medical and claims payment policies from States publically available web sites
- Requesting and receiving medical records from providers for sampled payments
- Conducting data processing reviews (on-site or remote) on all sampled claims and medical reviews on FFS claims
- Hosting the RC website which tracks all records requested/received, reviews completed and provides specific reports needed to track outcomes
- Visiting State offices and/or providing web-based calls for orientation to the RC process
- Conducts RC website orientation webinars/calls

States are critical partners in the PERM process and have the following responsibilities:

- Identifying and supporting a State representative who serves as the central point of contact and coordinate State PERM activities

- Educating all relevant State staff and vendors on the PERM process and data requirements
- Providing advance notification to CMS and contractors for any program changes, including new or ended programs, new reimbursement methodologies, or new systems
- Providing all claims and payment data to the SC in the required format and conducting quality control reviews prior to submission to ensure compliance with specifications
- Providing timely and thorough responses to any contractor questions on the State-submitted data to support the PERM timeline
- Educating providers on the PERM process and assisting with medical record collection

CMS also has specified responsibilities as partners in PERM. These responsibilities include:

- Structuring 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
- Providing guidance and technical assistance to States throughout the process
- Ensuring measurement remains on track and work with States when challenges occur
- Coordinating and hosting monthly calls with all cycle States
- Reviewing any State-requested appeals of error findings
- Providing educational resources for Medicaid and CHIP providers
- Providing assistance as States develop corrective actions
- Ensuring improper payments are recovered

Additional information on the responsibilities of the SC and RC is provided below.

10.5.1 Statistical Contractor

The SC has the following primary responsibilities: conducting Intake Meetings with the States prior to each cycle, collecting quarterly claims and capitation payment universe data, conducting quality review of the submitted data, selecting quarterly samples from the universes, calculating error rates, and creating error analysis reports to assist in States' corrective actions.

Conducting Intake Meetings with the States: The SC conducts an Intake Meeting with State policy, technical, and financial staff prior to the start of each PERM cycle. The meeting allows the SC to discuss with the State the specifications of and principles guiding the PERM universe, guidance for the State to build the FFS and managed care universe data for submission, types of payments included in and excluded from the PERM universes, data sources and documentation, and an overview of the overall PERM process with an emphasis on data quality review. The second component of this meeting involves the SC collecting relevant information about the State's Medicaid and CHIP programs, data systems, and FFS and managed care payment methodologies, including nuances of the State data and programs. The Intake Meeting serves as a

forum for the States to pose questions to the SC. Furthermore, the detailed discussions between the States and the SC help in shaping the State's PERM data submissions.

Collecting quarterly claims and capitation payment data: Each quarter throughout the PERM cycle, the SC collects Medicaid and CHIP FFS and managed care universe data from the States. Depending on the method of data submission predetermined by the State, the SC, and CMS, these data could be relatively clean PERM universes or relatively raw claims and payments. The quarterly submissions are due to the SC 15 days after the end of each quarter.

Conducting quality review of State submitted PERM universes: The SC performs extensive quality review of the universes submitted by the States. The review begins with the SC comparing the received quarterly data against the State-submitted summary of total records and dollars transmitted to ensure that no data were lost during transmission. Detailed checks are performed to ensure the data are not corrupted. If issues are identified during the initial quality review, the SC contacts the State to obtain clarification. Almost always, further processing cannot be conducted until these issues have been resolved.

Once the data have cleared the first stage of review, more in-depth quality checks are performed. In this phase, the SC's tasks include, but are not limited to ensuring that there are no: adjustments; payments not matched with federal dollars or are not fully adjudicated; unexpected or missing payment amounts; payments outside of the quarter; missing lines for relevant claims; and missing unique identifiers. The SC also reviews trends and patterns of payments within the State and across all States to ensure that the universes are accurate and PERM-compliant. The SC further compares the total dollars reported by the States in their CMS 64/21 reports with the dollars represented in the PERM universes. The comparisons allow the SC and the States to ensure that the PERM sampling universes contain all relevant federally matched payments.

As issues and questions arise during the quality review process, the SC will reach out to the State for resolution. It is important to note that the PERM universes must pass all stages of quality checks for samples to be selected. Therefore, State cooperation is extremely important.

Selecting quarterly samples from the FFS and managed care universes: From each FFS and managed care universe that has undergone all stages of quality review and deemed complete, complaint, and accurate for sampling, the SC selects a random sample of payments from each based on the sample sizes and sampling methodology shared with the States prior to the beginning of the cycle. The SC then reviews the selected samples to ensure that the information required by the RC to begin data processing review is present in the samples. If necessary, the SC will contact the State for additional information. The samples are then sent to the RC and to the States.

Depending on the method of the State's data submission, for FFS samples, the SC requests from the State or populates the "sample details" which consist of provider, beneficiary, and detailed service information for the sampled claims. These sample details go through in-depth quality review to ensure that the information necessary for the RC to conduct medical record requests are available. Once deemed complete and correct, the SC standardizes and formats the sample details and sends them to the RC.

Calculating State and national error rates: The SC calculates FFS, managed care, and overall error rates for Medicaid and CHIP on the national rolling, cycle, and State levels. Along with these error rates, the SC includes the total number of errors and total projected improper payments for the FFS and managed care components and overall programs on each level. The SC also calculates the State-specific FFS and managed care sample sizes for the next PERM cycle.

Creating error analysis reports to assist States' corrective actions: Based on the errors identified by the RC, the SC compiles State-specific and program-specific error analysis reports. These detailed reports include information on the errors found within the State sample, along with the types of errors and reasons for those errors. Each sampled claim in error is reviewed by the States, which use this information to formulate Corrective Action Plans (CAPs).

10.5.2 Review Contractor

The RC also has three primary responsibilities: collecting State policies, obtaining medical records for sampled payments, and conducting data processing and medical reviews.

Collecting Federal Regulations and State policies: Applicable federal regulations are collected that relate to timely filing requirements, ACA requirements for provider enrollment and risk based screening, HIPAA 5010 electronic claims standards and appropriate level of care and documentation standards. The RC researches and obtains State Medicaid and CHIP policies that are used for the medical and data processing reviews from States' publically available web sites. We also collect some documents that may not be available on States' web sites such as claims payment policies, fee schedules, and processing system navigational manuals for conducting review.

Requesting medical records: When the RC receives sampled claims detailed data from the SC, the RC contacts those providers whose FFS claims were sampled to obtain copies of medical records for the claims in question. If the record does not contain sufficient documentation, the RC requests additional documentation from the provider.

Conducting data processing and medical record reviews: When the RC receives the sample list from the SC, the RC schedules data processing reviews with each of the States. For FFS claims, the data processing review includes examining line items in each claim to validate that it was processed correctly. The RC also performs data processing reviews on managed care payments for the accuracy of the processing of the capitation payment or premium. The RC also conducts medical reviews on FFS claims (managed care claims are not subject to medical reviews because there is no specific service rendered on which to make a medical necessity determination). The RC examines the medical record to ensure there is documentation that supports the claim billed, medical necessity, and coding accuracy.

10.6 PERM Cycles

CMS uses a rotational approach to review the States' Medicaid and CHIP programs, so that each State is measured once every three years. At the end of each 3-year cycle, the rotation will repeat so that the FY 2012 States will be reviewed again in FY 2015; the FY 2013 States will be reviewed again in FY 2016; the FY 2014 States will be reviewed again in FY 2017.

CMS calculates a rolling national error rate, which combines the findings from the three prior measurement cycles, using information from all 50 States and the District of Columbia, to produce the improper payment rate for the current fiscal year, which is published in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). Each time a group of 17 States is measured under PERM, the previous findings for that group of States are dropped from the calculation and the newest findings are added in. The most current data from all 51 States are used in calculating the national error rate, called the national rolling error rate.

The States and their assignment within the rotation cycles are listed in Exhibit 1 below.

Exhibit 1. Medicaid and CHIP Measurement Cycles

Cycle	Includes Payments from These Fiscal Years	States
One	FY 2006 FY 2009 FY 2012 FY 2015	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Two	FY 2007 FY 2010 FY 2013 FY 2016	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Three	FY 2008 FY 2011 FY 2014 FY 2017	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

A CMS Cycle Manager is assigned to each PERM cycle. This person serves as the States’ main point of contact for that measurement, ensures the measurement timeline stays on track, and handles any issues that occur throughout a cycle.

10.6.1 Timeline

Exhibit 2 provides a timeline of major PERM activities for the States, SC, and RC for claims activities and a high-level timeline. Specific claims with due dates are addressed in Section 20 - Claims Universe and Sampling.

Exhibit 2. PERM Process Estimated Timeline

Timeframe	Event
July 1 (prior to federal fiscal year being measured)	PERM cycle begins
September 15	PERM Education sessions with CMS, SC, and RC begin
	States notify CMS and SC of method of PERM data submission (Routine PERM or PERM+)
October 1	State intake meetings with CMS and the SC begin
January 15	States submit 1st quarter (October – December) adjudicated claims to the SC
April 15	States submit 2nd quarter (January – March) adjudicated claims to the SC
April - September	RC researches and obtains States’ policies from relevant web sites
April	RC begins medical record requests when detailed data is received from the SC
July	RC begins data processing reviews on-site or remotely
July 15	States submit 3rd quarter (April – June) adjudicated claims to the SC
September (last month of fiscal year being measured)	RC begins medical reviews
October 15 (following the fiscal year being measured)	States submit 4th quarter (July – September) adjudicated claims to the SC
July 15	Typical CMS cycle cut-off date
August	RC submits final findings to the SC and the SC calculates error rates
November (two fiscal years after the fiscal year being measured)	National rates published in Agency Financial Report and States notified of State error rates and preliminary State- specific sample sizes for the following cycle
February	States submit Corrective Action Plans addressing identified errors
Throughout PERM process	States identify and resolve differences in review findings with the RC or through the appeals process
One year from discovery of an overpayment	States return the Federal Financial Participation (FFP) of identified FFS and managed care overpayments

10.6.2 Data Use Agreement

The RC and SC require access to sampling units stored in States’ MMIS and eligibility systems. The Medicaid Statute at section 1902 (a)(6) of the Act requires the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. Also, 42 CFR 430.32 is a parallel authority. CMS is operating the PERM program under the final rule FR/Vol. 75, No. 154 as published on August 11, 2010 in the Federal Register (42 CFR Parts 431 and 457).

The RC and SC are business associates of CMS pursuant to 45 CFR 164.502 (e) and under contract to perform the scope of work for the PERM project. The RC and SC were required to sign a business associate agreement as specified at 45 CFR 164.504 (e). CMS contractors must abide by terms and conditions of these contractual agreements, which incorporate HIPAA and Privacy Act provisions requiring security measures and imposing limitation on use.

10.6.3 Record Retention Requirements

PERM has several different record retention requirements:

Inputs – outgoing correspondence for reference of case activity, posting recoveries, account balances, recoupment activities, CMS-mandated reports and letters; eligible debts for collection; overpayment data from providers; Medicare Secondary Payer, Medicaid/CHIP claims data from States and medical records from Providers.

Disposition: Delete/destroy 5 years after cutoff, or when no longer needed for Agency business, whichever is later. (Disposition Authority: NARA’S GRS 20, item 2)

Master Files – outgoing correspondence for reference of case activity, recoveries, account balances, audit trail of recoupment activities, CMS-mandated reports and letters, eligible debts referred to Treasury for collection; provider overpayments; MSP, Medicaid/CHIP claims data, medical records from providers.

Disposition: Delete/destroy 10 years after cutoff or when no longer needed for Agency business, whichever is later. (Disposition Authority: N1-440-09-11)

Outputs – CMS Mandated Reports, Letters and Collection Referrals

Disposition: Delete/destroy 10 years after cutoff or when no longer needed for Agency business, whichever is later. (Disposition Authority: NARA’s GRS 20, item 6)

Adhoc Reports – **Disposition:** Delete/destroy 1 year after cutoff or when no longer needed for Agency business, whichever is later. (Disposition Authority: NARA’s GRS 20, item 16)

20. PERM Sampling Universe

The PERM methodology is based on sampling and review of individual payments from a universe of original, federally matched, and fully-adjudicated Medicaid and CHIP payments made by the States on behalf of individual beneficiaries to providers and other entities for medical services rendered. These samples are reviewed for errors, from which, State and national-level improper payments are extrapolated.

A complete and accurate universe is the foundation of PERM sampling and error rate estimation. The PERM error rates are intended to be representative of all Medicaid and CHIP payments, respectively, and the methodology is predicated on being consistent across States in a given cycle. The PERM States and the SC work together to define and compile the PERM sampling universe.

This section describes the specifications of PERM sampling universe, types of payments included in and excluded from the universe, and the process of submitting data to the SC for

sampling. Specific instructions for compiling and submitting PERM-compliant universe data are available on the CMS website.

20.1 Claim Universe Definitions

The PERM universe specifications are based on IPERIA statutory requirements, OMB guidance, and the PERM regulation. The scope of the PERM universe is bound by the following parameters, each of which is described in more detail below:

- Payment amount
- Payment date
- Program type

20.1.1 Payment Amount

IPERIA of 2012 defines an improper payment as a payment that was made in the incorrect amount, which includes both overpayments and underpayments.² While non-zero dollar payments made by the States are potential overpayments, denials and zero-dollar payments are potential underpayments. Therefore all three types of payments must be included in the PERM universe, provided they meet all other criteria for inclusion.

While the majority of the PERM universe is comprised of non-zero dollar payments, denials and zero-dollar payments are subject to sampling and review as well. Denials are claims which have been fully adjudicated, but denied for payment. Zero-dollar claims are those which have been approved for payment, but due to third-party or beneficiary obligation, the State bears no liability.

The PERM error rate is based on the total computable amount of the payment. This includes federal and State or local share. The total computable amount is the net of beneficiary (e.g. copays and coinsurance), third party (TPL), and other (e.g. taxes paid on waiver services) liability. For certain types of payments made by the States, the system may not retain the total computable amount (e.g. payments made by certified match or in-kind services). For all payments subject to PERM review, States must include the total computable amount in the PERM universe. In Section 30, we describe the PERM sampling methodology which underscores the importance of the correct total computable amount in the PERM universe.

20.1.2 Payment Date

The PERM sampling universe includes payments originally made or denied during the federal fiscal year under review. For example, for the FY 2016 PERM cycle, the universe includes claims and payments originally made or denied between October 1, 2015 and September 30, 2016.

To ensure consistency across States, PERM relies on the original paid or denial date to determine whether a payment is included in a given cycle. If a State originally pays a claim during the cycle under review, but adjusts the claim after the cycle, the claim is included in the PERM universe based on the original date of payment. Conversely, if a claim's original date of payment is prior to the PERM cycle, but an adjustment falls within the cycle, the claim is not included in PERM,

² http://www.whitehouse.gov/sites/default/files/omb/financial/improper/PL_111-204.pdf

again, based on the original date of payment. See Section 20.3.1 for more information on the treatment of adjustments in PERM.

If States make payments for prospective or retrospective periods of coverage, the payment should be included as of the actual date of payment. For example, if a State being measured in the October 1, 2015 to September 30, 2016 cycle, makes a retrospective capitation payment on October 5, 2015 for coverage in September 2015, the payment should be included in PERM, even though the State is purchasing coverage for a period outside the fiscal year being measured. Conversely, if a State in the same cycle makes a prospective capitation payment on September 30, 2015 for coverage in October 2015, the payment should not be included in PERM. Even though coverage is being purchased for a period inside the fiscal year being measured, the date of payment falls outside the measurement year.

20.1.3 Program Type

OMB guidance directs DHHS to measure Medicaid and CHIP as programs susceptible to significant improper payments. Therefore, separate universes are created for Medicaid and CHIP payments so that independent error rates can be estimated for each program. Each program is further separated into Fee-for-Service (FFS) and managed care components, based on capitation arrangements.

PERM universes are divided based on the federal financial participation (FFP) match received for the payments. The Medicaid universe includes payments matched with Title XIX and the CHIP universe includes payments matched with Title XXI funds. The CHIP universe contains payments made under both stand-alone and Medicaid expansion-type CHIP programs (where beneficiaries are enrolled in Medicaid, but their claims are matched with Title XXI FFP).

For denials and zero-dollar paid claims, the appropriate PERM universe is determined by the type of FFP, had the claims not been denied or had the claim not had other liability. Similar to claims and payments where the State has financial liability, it is imperative to identify the appropriate universe for denials and zero-dollar claims.

20.1.3.1 Services Matched with Both Title XIX and Title XXI Funds

States may have services that are matched with both Title XIX and Title XXI funds. These payments must be brought to the SC's attention prior to the start of the PERM cycle so that the most appropriate universe for these payments can be identified.

20.1.3.2 Denials that Cannot be Identified as Medicaid or CHIP

States may have denials for which the type of FFP had the claims not been denied cannot be determined. States must bring these payments to the SC's attention prior to the start of the PERM cycle so that the most appropriate universe for these payments can be identified.

20.2 Fee-for-Service and Managed Care Components

This section discusses the components of Medicaid and CHIP universes – FFS and managed care. Also subject to inclusion in the PERM universe are non-managed care fixed or capitated payments, payments made in the aggregate, and health reform-related payments made in

compliance with the Affordable Care Act (ACA). Each of these types of claims and payments must be matched with Title XIX and Title XXI funds and must meet all other criteria for inclusion in PERM. They must also be made on behalf of individual beneficiaries to purchase medical services.

20.2.1 Fee-for-Service (FFS) Payments

FFS is a traditional method of paying for medical services under which providers are paid for each service rendered to individual beneficiaries. FFS payments in Medicaid and CHIP generally include individual professional, clinic, lab/x-ray/DME, pharmacy, home and community based services (HCBS), and hospital claims processed through the MMIS or other payment systems, including State agencies and third party administrators (TPA).

20.2.2 Managed Care Payments

Managed care is a system where the State contracts with MCOs on a full or partial-risk basis, to deliver health services through a specified network of providers. The MCO is then responsible for reimbursing providers for specific services delivered. Managed care payments can include capitation payments made for a comprehensive package of services (full capitation), for a limited package of services (partial capitation), or for specialty managed care programs for which the capitated provider is at risk (e.g., PACE and behavioral health).

The PERM managed care universe also includes supplemental negotiated rate payments made to MCOs on behalf of individual managed care enrollees, such as maternity “kick” payments, delivery supplemental payments, and newborn supplemental payments. Reinsurance or stop-loss payments made for managed care enrollees are not included in the managed care universe; rather they are included in the FFS universe as fixed payments.

The single State agency, or Medicaid or CHIP agency may make payments or transfers to another State agency on a capitated or per-member-per-month (PMPM) basis using either budget-derived payment amounts or actuarially-certified capitation amounts. Payments from one State agency to another are not considered to be managed care payments in PERM because State agencies, even those operating as public MCOs, are not entities that assume risk. In these cases, the underlying FFS payments would be included in the PERM universe. Reviewing the payments made by the State agency that is responsible for paying providers using Medicaid and/or CHIP dollars allows the State and CMS to have an estimate of improper payments made at the State level.

20.2.3 Small FFS or Managed Care Universes

States may not have payments for one of the components – managed care or FFS. Also, there are instances where one component is very small in terms of expenditures, relative to the other component and overall State program (Medicaid or CHIP) expenditures included in PERM. For instance, the program for all-inclusive care for the elderly (PACE) is the only managed care program in Medicaid or the State’s CHIP program is entirely in managed care, except for a small vaccination program which is paid by the FFS. Applying the normal rules of universe creation to a small component will result in a very large proportion or all of the payments in the component being sampled. In that case, the component error rate will essentially be the error rate of the single small program or payment type. This would result in a much higher level of scrutiny to this small program than what is applied to other services or programs, and would ascribe much

more importance to the associated error rate (by terming it a “component” error rate) than a program of this size deserves.

PERM precedence guides combining the very small component and the large component into a single universe where the former accounts for less than two percent of total expenditures for the State’s program. For instance, if the total expenditures associated with the State’s only managed care program, PACE, is less than two percent of the total Medicaid expenditure, then PACE would be included in the Medicaid FFS universe. Similarly, if the State’s only FFS program for CHIP beneficiaries accounts for less than two percent of the total CHIP expenditures, then this vaccination program would be included in the CHIP managed care universe.

States must bring possible small components to the SC’s attention prior to the start of the PERM cycle so that the most appropriate universe for these payments can be identified.

20.2.4 Non-Managed Care Fixed Payments

Besides managed care capitation payments and FFS claims, Medicaid and CHIP programs make a variety of other types of payments on behalf of individual beneficiaries which are subject to PERM review. These could include non-risk capitated PMPM payments for programs such as primary care case management (PCCM), disease management, and non-emergency medical transportation (NEMT). Additionally, payments made to individuals or health plans through health insurance premium payment (HIPP) programs, reinsurance or stop-loss payments to managed care organizations, and drug administration capitations to nursing facilities are also included in PERM. The PERM sampling universe also includes premium payments made by the States toward Medicare Part A and Part B for dual-eligible beneficiaries. The SC collects these premium payment data from CMS and not from the States.

States need to discuss certain payments, such as special incentive payments to providers, or payments made under an 1115 waiver to non-enrolled beneficiaries, with CMS and the SC to determine if they are appropriate for inclusion in the PERM universe. Although there may be exceptions, these payments are typically included in the FFS universe as “fixed payments.”

20.2.5 Aggregate payments

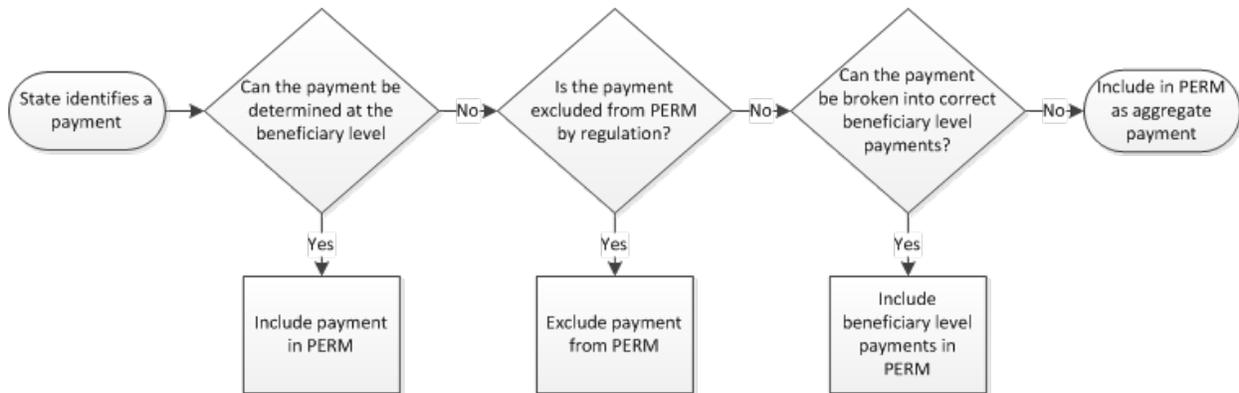
While most Medicaid and CHIP payments are made at the beneficiary level, States may also calculate and pay for certain services on behalf of a group of beneficiaries. PERM broadly refers to these as “aggregate payments”. Unless otherwise specified by CMS, aggregate payments for services are subject to sampling and review in PERM. These payments are included in the PERM universe regardless of whether the State claims FFP at the medical services match rate or as an allowable administrative cost.

Examples of aggregate payments are pay-for-performance incentive payments made to individual providers based on the claims experience of a group of beneficiaries; reimbursement to counties for NEMT services provided to all Medicaid beneficiaries residing in that county; contractually agreed upon aggregate payments to a broker for provision of transportation services; and fees paid to a case management vendor based on the number of beneficiaries enrolled in the program each month.

In certain cases, States may determine payments at the individual level, but maintain payment records at the aggregate or invoice level. In these cases, CMS and the SC will work with the State to determine how the payment should be submitted and reviewed for PERM.

Aggregate payments lack fundamental consistency as payment methodologies and documentation can vary significantly across States. To assist in handling aggregate payments consistently and appropriately for PERM, CMS developed the following framework displayed in Exhibit 3, below.

Exhibit 3. PERM Aggregate Payment Framework



The framework walks through each step of the process used to determine whether a PERM payment should be submitted in aggregate form for inclusion in the universe. Each step has a decision point which requires State input on the payment, its methodology, and its availability. Answers to each question will assist the SC in working with the State on how to address each individual aggregate payment.

States should work with CMS and the SC to determine how payments should be submitted and reviewed for PERM. It is important to note that the definition of aggregate payments continues to evolve for PERM as States continue to develop innovative payment methodologies. CMS, the SC, and the RC will continue to evaluate which payments are considered aggregate payments for PERM. It is possible that an aggregate payment not included for PERM in a past cycle could be determined to be an aggregate payment for inclusion in a future cycle.

20.2.6 Health Reform-related and Other Incentive Payments

In light of the ACA and other State-initiated health reform activities, many States have implemented or plan to implement new programs to support efficiency and quality in health care delivery using Title XIX and/or Title XXI funds. If these payments are calculated at the beneficiary level, they likely are to be included in the PERM universe, even if they are made in aggregate. For example, many States have made retrospective payments to primary care providers to meet the requirements of Section 1202 of the ACA. These payments were often made in aggregate, but were calculated at the beneficiary-level and were matched by federal funds, and therefore were subject to sampling and review under PERM.

20.3 PERM Exclusions

The PERM sampling universe is guided by the rule that each beneficiary-specific payment matched with Title XIX or Title XXI funds should have one chance, and only one chance, of being sampled. Therefore, it is imperative that each payment is included in the PERM universe only once.

The PERM sampling universes must contain payments that are original, federally matched, and fully adjudicated and approved or denied for payment. This means that adjustments to original payments, State-only payments, and payments that are not fully adjudicated are excluded from the PERM universes. Further excluded from the PERM universes are encounter records for capitation or other encounter-based payments. By PERM regulation, payments made for solely administrative purposes and certain other types of payments made to providers are excluded from the PERM sampling universes. In this section, these PERM exclusions are described in detail.

20.3.1 Adjustments

Since each payment is included in the PERM universe once and only once, the universe may not have the original payment and adjustments. To ensure consistency across States and programs, PERM universes include only original payments. Therefore, all forms of adjustments, including voids, replacements, and adjusted claims or payments must be excluded from the universe.

As noted earlier, to ensure consistency across States, PERM relies on the original date of payment to determine whether a payment falls within a given cycle measurement. For example, a State being measured in the October 1, 2015 to September 30, 2016 cycle that makes an original payment on September 15, 2015 and voids and replaces the claim on October 2, 2015. In this case, the original payment will not be included in the PERM universe as it falls outside of the measurement year, even though the adjustments took place during the measurement year. Conversely, if that State makes a payment on September 15, 2016 and subsequently adjusts it on October 2, 2016, the payment must be included in the PERM universe (provided it meets all other criteria for inclusion), since the original payment date falls within the measurement year.

In PERM, the dollar amount in error is the difference between what *was* paid and what *should have been* paid. The original payment amount is used to determine what was paid, and is compared to what *should have been* paid. However, if a payment is adjusted within 60 days of the original payment date, the adjusted amount will be used to determine what *was* paid, and will be compared to what *should have been* paid. Adjustments made outside of this 60-day window will not be considered. When the data processing reviews are conducted, the reviewer will collect and consider all adjustments made within 60 days of the payment date. In the above example, for the claim originally paid on September 15, 2016, the adjustment made on October 2, 2016 will be considered for review purposes since it is within the 60-day window.

Commonly, claims adjustments for Medicaid and CHIP are made through individual adjustments and mass adjustments, described below. In rare occasions, the State may have replacement claims as a result of a void-and-replace form of adjustment, which cannot be distinguished from the original payments. The State must bring such instances to the attention of CMS and the SC so that the appropriate inclusion and exclusion strategy may be identified.

20.3.1.1 Individual Claims Adjustments

In most cases, the adjusted claims are processed to correct an error. Adjustments to individual claims can be initiated by either the provider or the payer.

- *Provider-initiated individual adjustments:* A provider can submit a request for a claim adjustment for a variety of reasons including, but not limited to, errors in number of units or medical codes billed, incorrect beneficiary information, and incorrect medical/service codes.
- *State-initiated individual adjustments:* States may also adjust claims on an individual basis as a result of claims audit, review, surveillance, etc.

20.3.1.2 Mass Adjustments

States, on occasion, make mass adjustments to the payments they previously made to providers. Two of the most common reasons for mass adjustments are:

- *Changes in reimbursement rates to providers:* In some cases, provider fee adjustments become effective prior to the time when the claims payment system can be adjusted to reflect the change in fee schedule. If a State makes a payment according to an old payment schedule after the effective date of the updated payment schedule, either because the effective date was retroactive or because the system changes necessary to make the new payment were not completed by the effective date, this payment, even if outside the 60-day window for adjustments, will not be considered an error in the PERM review.
 - A typical example is when regulations mandate fee increases (or decreases) and the necessary changes to the claims payment system cannot be implemented by the effective date of the fee schedule change. The State typically makes a mass adjustment to the paid claims to ensure that the providers are reimbursed the amount mandated by the updated regulations.
 - Another example is when providers successfully sue the State for having inadequate fees for certain services, in violation of the Title XIX statutory requirement that payment rates be consistent with economy, efficiency, and quality of services. If the judicial remedy includes retroactive fee increases, the State is obligated to make mass adjustments.
 - A final example is rate or benefit changes through State Plan Amendments (SPAs) where the effective date of the SPA is prior to the approval date. States typically make mass adjustments to ensure that the provider reimbursements reflect the changes in policy.
- *Cost-based payment rates:* In many States, certain Medicaid payment rates, such as institutional (hospital and nursing facility), federally qualified health centers (FQHCs), and rural health centers (RHCs), are cost-based. For these providers, a cost settlement is completed to establish the final cost-based rate. A mass adjustment is then made to account for the difference between the interim and final rates. Similarly to retroactive rate changes, PERM will review the payment based on the pricing schedule on file at the time the payment was made and will not consider it an error if prices are changed retroactively due to cost settlement outside of the 60-day adjustment timeframe.

20.3.2 State-Only Payments

The PERM universes include only payments matched with federal Title XIX or Title XXI funds. Payments that do not receive either are identified as State-only for PERM purposes and are excluded from the universes. This is because the PERM program only reviews payments that have federal liability for potential improper payments. The State may have programs for which no federal match is received. The State may also make payments on behalf of certain groups of beneficiaries but receive no federal match. For the latter example, all payments for these beneficiaries are considered as State-only.

20.3.3 Payments not Fully Adjudicated

The PERM universes include only claims that have been fully adjudicated. CMS defines a fully adjudicated claim as one that has been reviewed by a person or a system completely and has been approved or denied for payment. Claims that are either in process or are suspended for review are not considered to be fully adjudicated. Rejected claims (e.g., claim batches rejected by a pre-processor) that never made it to the State's adjudication process are also not included in the PERM universes.

States may have certain types of claims where the rejected claims cannot be distinguished from the denied claims. The State must bring these to the attention of CMS and the SC so that the appropriate inclusion and exclusion strategy may be identified.

20.3.4 Administrative Payments

PERM universes include only claims and payments representing services rendered to individual beneficiaries, or capitation payments purchasing a package of services on behalf of individual beneficiaries. These payments could either be matched at the medical services match rate or as an allowable administrative cost.

PERM universes do not include payments solely made for administrative functions, such as payments to fiscal agents, salaries of State employees, or funding for program outreach. In instances where rates blend administrative and service payments, the entire payment must be included in the PERM universe.

20.3.5 Payments Excluded by Regulation

The PERM regulation explicitly excludes specific types of payments from the universes. These typically do not represent payments made on behalf of individuals for services. Regulatory exclusions include:

- Disproportionate Share Hospital (DSH) payments
- Drug rebates
- Grants to State agencies or local health departments
- Graduate Medical Education (GME) payments made as a lump-sum
- Cost-based reconciliations to non-profit providers or FQHCs not tied to individual claims

20.3.6 Encounter Data

The PERM universes include only true payment records based on which, federal match is received. Therefore, encounter data or “shadow claims” are excluded from the PERM universes. For PERM purposes, encounter data are defined as informational-only records submitted to a State by a provider or an MCO for services covered under a managed care capitation or encounter payment. While these are beneficiary specific, encounter data do not represent actual payments made by the State. Therefore, they are excluded from the PERM universes.

States often collect encounter data to track utilization, assess access to care, and possibly compute risk adjustment factors for at-risk MCOs. States may also require encounter data from FQHCs, RHCs, and Indian Health Services (IHS) clinics paid at an encounter rate. Further examples of encounter claims include records for State-supplied vaccines and shadow claims for programs paid by Certified Public Expenditure (CPE).

20.4 PERM Data Submission

CMS requires each PERM State to submit a quarterly universe of all PERM-compliant Medicaid and CHIP payments from which the SC will select samples. In this section, the methods of PERM data submission, documentation, recommended quality checks by the States prior to submission, due dates, and data security are discussed.

20.4.1 Methods

There are two methods of data submission available to the States – Routine PERM and PERM+. States electing either option must continue to use it throughout the cycle.

20.4.1.1 Routine PERM

The Routine PERM data submission process requires two data submissions from the States. The first data submission contains complete Medicaid and CHIP universes. CMS requires that the universe data conform to the list of requirements described above to ensure consistency across States. The submission must not include any of the PERM exclusions. This data submission facilitates the SC to create clean universes from which samples can be selected. The second data submission contains detail information for the sampled FFS payments. These sample details are required for medical record requests.

Please refer to the CMS PERM website for the Routine PERM Universe and Details Data Submission instructions.

20.4.1.2 PERM+

PERM+ is a data submission process developed by CMS to simplify PERM for the participating States. Through PERM+, States submit relatively raw quarterly claims, recipient, and provider data. Each State, in conjunction with CMS, decides if data will be submitted via the PERM+ method prior to the SC’s Intake Meeting with the State. States must notify CMS by September 15 prior to the PERM cycle being measured if they intend to use PERM+ to submit some or all of their data.

Unlike in Routine PERM, in PERM+, the SC is responsible for developing the universes by removing PERM exclusions with the States' guidance. States submitting under PERM+ do not have to develop the details for sampled claims, as the SC receives all necessary claim, provider, and recipient information with the one data submission and is able to append them to the sampled claims. If the SC has inadequate information for the sampled claims or requires clarification, the States will be contacted as necessary.

Please refer to the CMS PERM website for the PERM+ Data Submission Instructions.

20.4.2 Documentation

Data documentation is a critical component of each PERM submission. Complete documentation saves time by reducing errors, re-work, and questions from the SC to the States. At a minimum, each PERM submission should accompany the following –

- Transmission cover sheet – This document provides information about the files sent to the SC
- Control totals – These totals help the SC to ensure that no data have been lost or corrupted during transmission
- Data dictionary – This document provides decode information for State-specific values in the PERM data submission
- File layout – This document lists the fields included in the data submission along with their type, format, and length

20.4.3 Claims Data Submission Due Dates

PERM data submissions are due to the SC 15 days after the end of each quarter as shown in Exhibit 4, unless the due date falls on a weekend or federal holiday, in which case the due date is the next business day. These dates are applicable for both Routine PERM and PERM Plus methods of submission.

Exhibit 4. Claims Data Submission Due Dates

Quarter	Claim Date Paid	Data Submission Due
Quarter 1	October 1 – December 31	January 15
Quarter 2	January 1 – March 31	April 15
Quarter 3	April 1 – June 30	July 15
Quarter 4	July 1 – September 30	October 15

20.4.4 Claims Data Quality Review

States are required to review the PERM data prior to submission and certify the accuracy and validity of the submission. Thorough data quality review by the States prior to PERM submission saves time by reducing errors, re-work, and questions from the SC. States are urged to compare expenditures represented in the PERM submission with their CMS-64/21 reports to ensure that payments that should be included in the PERM submission are included. Refer to the Data Submission Instructions on the CMS PERM website for instructions and guidance on data quality review and on comparing PERM data to CMS Financial Management Reports.

20.4.5 Data Security

Under PERM, States submit data that contains protected health information (PHI), including electronic protected health information (ePHI), and personally identifiable information (PII). Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CMS, its contractors, and States are all responsible for ensuring the security of PHI and PII that they maintain, transmit, disclose, or dispose. Information security requirements must safeguard against the potential breaches of ePHI and PHI. CMS requires States, its contractors, and other business associates to adhere to Federal standards for the adequate encryption of PHI or PII prior to transmission and that any passwords are sent securely and separately from the transmitted data, regardless of the method of transmission. PHI or PII should never be sent by email.

Under HIPAA, covered entities must ensure the secure transfer of PHI and PII contained in any data transmissions. To meet this requirement, CMS requires all State data transfers containing PHI and PII be encrypted with software that is compliant with the Federal Information Processing Standards (FIPS) 140-2, and validated by the National Institute of Standards and Technology (NIST) module.³ The software should also have key management, which allows the State's system administrator to have the authority to unlock all encrypted files from the State's system. This method prevents the necessity of sharing the password with others at the State if the State contact person sending the data to the contractor is unavailable to provide the key.

In the event of a breach of PHI or PII, CMS requires States, its contractors, and other business associates to adhere to the breach notification rules as mandated under the Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act (ARRA) of 2009.⁴

The CMS contractors will provide States with instructions on data submission that meet CMS security requirements. If a State requires a Data Use Agreement (DUA) with a PERM contractor prior to submitting data or allowing system access for payment reviews, the draft DUA must be submitted to CMS for review by October 1 at the beginning of the cycle. CMS will forward the DUA to the appropriate contractors for review and approval. The terms of a DUA will be negotiated between the State and the PERM contractors.

30. PERM Sampling Process

The goal of PERM is to measure and report an unbiased estimate of the true error rates of Medicaid and CHIP. Because it would be impossible to review the accuracy of every Medicaid and CHIP payment, CMS uses a statistically valid methodology to select small samples of payments from the Medicaid and CHIP universes, then extrapolates from the review findings for the samples to estimate the error rate for the program universes.

³ FIPS 140-2 can be found at: <http://csrc.nist.gov/groups/STM/cmvp/standards.html>. NIST module can be found at: <http://www.csrc.nist.gov/groups/STM/cmvp/index.html>

⁴ The HIPAA Breach Notification Rule, released by OCR/HHS, applies to HIPAA covered entities. This Rule may be accessed at: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html>. The Health Breach Notification Rule, released by the FTC, applies to non-HIPAA covered entities. This Rule may be accessed at: <http://ftc.gov/healthbreach/>.

PERM is designed to fulfill the requirements of IPERIA by calculating Medicaid and CHIP error rates that meet certain precision and confidence requirements. For each State, separate error rates are estimated for Medicaid and CHIP based on a sample of payments. If a State has both FFS and managed care, separate component error rates are estimated, then weighted together according to expenditures.

In this section, we describe PERM sampling units, sampling process including sample size determination, stratification, and error rate estimation.

30.1 Sampling Units

The PERM methodology is based on sampling and review of individual payments from a universe of State Medicaid and CHIP payments (as specified in the previous section) to identify payment errors, from which State and national-level program error rates are extrapolated. Each payment in the PERM universe, including FFS, managed care, or aggregate, is considered an individual “unit” for sampling purposes. Each sampling unit is the smallest level of individually-identifiable payment and as discussed previously, must have one and only one chance of being sampled. Therefore, it is imperative to ensure that the universe does not have multiple occurrences of a sampling unit.

30.1.1 General sampling unit definitions

For most individual beneficiary-level claims and payments the sampling unit is a claim, line item, managed care capitation payment, fixed payment, or other individually-priced service tied to a single beneficiary. If a State calculates the payment amount for a claim at the line item or “detail” level, the line is the sampling unit. The State must include all of paid (including zero-dollar paid) and denied lines for that claim in the PERM universe. For example, physician claims usually report an individually-priced service on each line of a claim (i.e. a claim may have five lines representing five individually-priced services). Since the paid amount for each line on the claim is determined independently of the other lines, the State must include each line in the PERM universe.

If the payment amount is calculated at the claim level (e.g., a DRG, per diem or encounter-based payment), the sampling unit is the header record containing only the claim-level information. A hospital claim that pays on a DRG basis may include 20 additional revenue lines, but the paid amount for all of the services are calculated based on the DRG reported on the header. In this case, only one record representing the header level payment for the DRG should be in the PERM universe. The 20 lines on the claim are informational details because they are not priced separately and therefore, are not considered sampling units.

30.1.2 Claim-specific exceptions

States may need to identify claim-specific exceptions to payment level rules. For example, out-of-State hospitals are excluded from the DRG methodology and each claim detail is paid on a percent-of-charges basis. In this case, the out-of-State hospital inpatient claims would be included in the PERM universe at the line level even though all other hospital inpatient claims are included at the header level. Other claim/provider types where there are often exceptions to the general header/detail payment rules include Medicare crossover claims, claims from FQHCs, RHCs, and IHS clinics, and claims from State-owned facilities.

Third party liability (TPL) and beneficiary cost sharing (co-payment and coinsurance) may also affect the level at which a PERM sampling unit is determined. If, for a claim paid at the detail or line level, TPL or beneficiary cost sharing is deducted from the overall claim's allowed charge, the particular claim with TPL must be included in the PERM universe at the header level. This is because the sum of the details payment amount is not equal to the amount reimbursed by the State. In this example, the claim would be included in the PERM universe as a header level sampling unit to reflect the total computable amount for the claim.

For aggregate payments, the sampling unit for PERM is generally the lowest level for which a payment entry (record, invoice, or claim that the State uses to determine the payment amount) is available electronically. CMS, the SC, the RC, and the State may need to work together to determine the appropriate sampling unit for aggregate payments and the appropriate review methodologies.

30.2 Claims Sampling Process

IPERIA requires an estimated national error rate bound by a 90 percent confidence interval of 2.5 percentage points in either direction of the estimate. That is, the sample must be large enough that, given standard statistical assumptions, one can be 90 percent confident that the error rate for the sample is within plus or minus 2.5 percentage points of the true error rate for the universe. Selecting a larger sample size can increase the confidence that the sample error rate is closer to the universe error rate, and/or decrease the size of the range around the estimate. CMS has chosen, for PERM, to draw samples at the State level that allow an estimated State error rate with a 95 percent confidence interval of three percentage points in either direction.

Although separate samples are drawn for Medicaid and CHIP, the procedures for sampling are the same for both programs. This section distinguishes between Medicaid and CHIP only when differences occur.

30.2.1 Sample Size for Claims and Capitation Payments

For fee-for-service claims and capitation payments, the State-level PERM sample size is the number of sampling units determined necessary to calculate an estimated error rate for a State bound by a 95 percent confidence interval of three percentage points in either direction.

As previously noted, on February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) was enacted. Section 601(f) of the CHIPRA required CMS to establish State-specific sample sizes for application of the PERM requirements with respect to CHIP for fiscal years beginning with the first fiscal year that started on or after the date on which the final rule was in effect for all States, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable: (1) minimize the administrative cost burden on States under Medicaid and CHIP; and (2) maintain State flexibility to manage such programs. CMS published the final PERM rule on August 11, 2010 (75 FR 48815), and the State-specific sample size provision went into effect with the FY 2011 PERM cycle.

The final rule established State-specific sample sizes for PERM, although the execution of these responsibilities remains with CMS and the Federal contractors, not with the States. Under the

Secretary's authority at section 1102(a) of the Act and in order to effectively implement the IPERIA, CMS applied these sampling procedures to both Medicaid and CHIP.

In addition, CMS established a maximum sample size of 1,000 claims for each component. Because reviewing claims requires both staff and monetary resources, a maximum sample size puts a limit on expenditures. Statistical tests suggest that if State-level precision cannot be met with a sample size of 1,000 claims, it is unlikely to be met with any reasonable sample size; however, a substantial increase in the probability of reaching precision goals can be gained by increasing the sample size from 500 to 1,000.

The SC estimates State-specific sample sizes for each program component within each State based on the prior cycle's error rate and whether the precision requirement was met in the prior cycle. The State-specific sample size must be sufficient to meet the precision requirements, which is to estimate the component error rate with a 95 percent confidence interval of three percentage points in either direction.

30.2.2 Fee-for-Service Stratification

For FY 2014 and later PERM cycles, FFS universes are stratified by a hybrid approach of service-based strata and dollar-weighted strata. The SC uses State's data and data dictionaries to determine how to assign the claims to the service strata. During this process, the SC works in close collaboration with the States to determine the most appropriate assignment for each type of claim or payment.

Using claim-specific information submitted by the State (e.g., claim type, provider type, service code, etc.), the SC, with the State's approval, assigns each sampling unit in the FFS universe to one of four service-based strata. Note that the service-based strata vary by program. All payments that do not fall into one of these service-based strata will be sampled from three dollar-weighted strata. All denied and zero-dollar paid claims and lines will be sampled from a separate stratum. The service-based strata are, as follows:

- Home-Based and Community-Based Services, Rehabilitation, and Hospice (Medicaid and CHIP)
- Physician, Dentists, and Other Practitioners (Medicaid and CHIP)
- Pharmacy (Medicaid and CHIP)
- Long-Term Care (Medicaid only)
- Inpatient Hospital (CHIP only)
- Other (dollar-weighted; Medicaid and CHIP)
- Zero-dollar paid/denied payments (Medicaid and CHIP)

Each of the service-based strata is further divided to two substrata – high and low dollar. The high dollar sub-stratum represents the top 30% of the payments in the service-based stratum and the low dollar stratum represents the bottom 70% of the payments in the stratum. From each of the service-based sub-stratum, a minimum of two samples are selected on a quarterly basis. From the stratum containing zero-dollar paid and denials, two samples are selected, and from each of the three dollar-weighted sub-strata in the "Other" stratum, a minimum of two samples are selected in each

quarter. After allocation of minimum sample sizes for each stratum, the rest of the quarterly sample is allocated in proportion to the payment size for each stratum in the quarter.

It is possible that for a few States, a service stratum or sub-stratum may not have any payments or may have fewer payments than the minimum sample size of that stratum or sub-stratum. In cases when a stratum does not contain any payments, the minimum sample size for the stratum is zero. If a stratum has fewer than the minimum sample size in the universe, all available payments are selected in the sample. Both scenarios increase the number of sampled claims that can be distributed proportionally by the total dollars in each of the other stratum, and are more common in CHIP universes due to their small sizes.

The claim categories used to stratify the samples are different from the categories used to categorize claims and payments for medical record review. Please refer to Section 70.1 for a listing of the claim categories used for medical record review.

30.2.3 Managed Care Claims Payment Stratification

A dollar-based stratification approach is used for the managed care sample. Each program area is divided into strata based on payment amounts. For FY 2011 and later years, 10 dollar-weighted strata are used for managed care sampling. The total payments in the universe are divided by the number of strata and an equal proportion of payments are included in each stratum. Therefore, each stratum for managed care sampling includes 10 percent of the dollars in the universe. Payments are sorted and applied to each stratum, so that a small number of high-dollar payments are placed in the first stratum, and a large number of very small payments are placed in the last stratum.

Below, an example of dollar-weighted stratification is summarized. For the sake of simplicity, the following example assumes five dollar-weighted strata. This is consistent with the methodology applied for 10 dollar-weighted strata. If five strata are used, each stratum would contain 20 percent of total payments, but if 10 strata were used, each stratum would contain 10 percent of total payments. The following example assumes five strata:

Step 1: The total amount of all payments is divided by five to determine the dollars that need to be allocated into each stratum (20 percent of expenditures).

Step 2: All lines are sorted from largest to smallest payment amounts.

Step 3: Lines are selected in descending order until there are sufficient lines, added together, to represent 20 percent of total payments. This is the first stratum.

Step 4: The second stratum consists of the next largest lines that represent 20 percent of total payments.

Step 5: This sequence is repeated until all five strata are constructed. The fifth stratum is the one that always contains all denied lines (denials are rare in managed care programs, but do occur in some States). Denials have a zero dollar amount and therefore will appear in the stratum with the smallest dollar values.

Step 6: An equal number of lines are then sampled from each of the strata (e.g., if the sample size is 250, then 50 lines are sampled from each stratum).

Note that the first stratum will have the fewest number of lines (the lines in the first stratum are the highest-dollar lines, so it takes fewer of them to add up to 20 percent of expenditures), while the last stratum will have a very large number of lines. Therefore, this strategy has the additional implication that the sampling frequency in the first stratum, with the high dollar-valued lines items, will be greater than the sampling frequency on the last stratum, where very low dollar-line items are included. Put another way, higher-dollar claims have a greater chance of being sampled. See Exhibit 5 below.

Exhibit 5. Stratification by Expenditures - Five Strata Example

	Stratum 1 (Largest claims)	Stratum 2	Stratum 3	Stratum 4	Stratum 5 (Smallest, denials, zero paid)	Strata <i>All</i>
Number of lines	18,965	25,099	29,841	83,412	359,476	516,793
Percent of total	4%	5%	6%	16%	70%	100%
Total amount paid	\$4,696,625	\$4,696,748	\$4,696,679	\$4,696,770	\$4,696,719	\$23,483,540
Percent of total	20%	20%	20%	20%	20%	100%
Sample distribution	50	50	50	50	50	250
Sampling frequency	50/18,965 or 1 out of every 379	50/25,099 or 1 out of every 502	50/29,841 or 1 out of every 597	50/83,412 or 1 out of every 1,668	50/359,476 or 1 out of every 7,190	N/A

30.2.4 Sample Selection Process

The general process used to select a sample is summarized below.

Step 1: Define necessary strata according to the sampling methodology specific to the program and component and sort all lines into the appropriate stratum.

Step 2: Sort all lines in each stratum first by paid amount and then by a random number (the random number is used to order payments with the same dollar amounts).

Step 3: Determine the skip factor for each stratum (k_i). Let N_i be the number of payments in the universe for the i^{th} stratum and n_i be the number of payments in the sample for the i^{th} stratum.

$$k_i = \frac{N_i}{n_i}$$

Step 4: Determine a random start value for each stratum ($start_i$), such that $1 \leq start_i \leq k_i$.

Step 5: Sample every k_i^{th} item within the i^{th} stratum.

30.2.5 Modifications to the Sampling Process

The previous section provides the sampling procedure when the universe information is accurate. In practice, problems with the universe data due to a myriad of reasons are often discovered after a sample had been selected and review is under way. Although ideally that sample should be dropped from review and a new sample should be selected from the corrected universe, in the interest of time and burden of the RC and the State, selecting a replacement sample may not be feasible. In such situations, the following steps are taken to correct the sample:

Step 1: A correct universe is created using updated data provided by the State.

Step 2: Sample sizes needed for each stratum are recalculated from the corrected universe.

Step 3: All lines in the original sample that exist in the corrected universe are retained in the corrected sample, if it is possible to do so while preserving a valid sample.

Step 4: Additional sampling, to eliminate any difference between the new required sample size for each stratum and the valid portion of the original sample, is taken from the corrected universe.

Step 5: Before sampling, all claims from the original sample are withdrawn from the corrected universe and accurate sampling frequencies are calculated.

Step 6: The sampling procedure described in the previous section is applied to the additional sampling from the corrected universe.

Following these steps ensures the randomness of the sample within each stratum and that accurate sampling frequencies can be calculated so that the population inferences remain unbiased. There might be cases where this process results in more than the required number of lines in a stratum due to the reallocation of the sample prescribed by the corrected universe file.

40. State Policy Collection Process

The RC is responsible for acquiring Medicaid and/or CHIP policies for each State selected for review for the PERM cycle. The RC is also responsible for maintaining a database that contains a complete set of policies for each selected State governing their respective Medicaid and/or

CHIP programs and the claims under review during the PERM review cycle. Policies used in the

PERM review may include:

- Rules/regulations
- Manuals/handbooks
- Bulletins/updates/notices
- Clarifications/reminders
- Fee schedules/codes

- State Plan Amendments (as relevant and approved by the Centers for Medicaid and CHIP Services (CMCS))

The RC will contact each State at the beginning of each PERM review cycle. The RC begins the policy collection process by researching the State website(s) for all available State policy documents that contain Medicaid and/or CHIP policy documents relevant to the medical review of claims, and downloads these from the State website. If a policy update alert system exists, the RC will apply to receive updates of all policy changes from the State. The RC then downloads all policies, converts them to text-searchable formats if necessary, and compiles a master list of all policies for each State. After the completion of the Master Policy List, the RC sends the list of policies to the State and requests that they verify in writing that the list is complete (or supplemented when needed). The RC continues to collect State policies throughout the measurement year, and validates the list with the State as appropriate.

50. Medical Record Request Process

The RC is responsible for requesting all medical record documentation associated with the randomly selected Medicaid FFS and CHIP FFS claims. The requests will be submitted directly to the provider's medical record location as verified by the provider. Providers have a 75-day window to submit the medical record documentation. At a minimum, the RC will send four letters and make four phone calls to each provider throughout the 75-day window, as needed, to follow up on documentation not yet received. The user's guide for the PERM RC's website where States can track medical record requests is included on the website's homepage.

50.1 Provider Contact Validation

By referencing sampled claims, the RC first verifies the provider information by contacting either the performing provider or the billing provider by phone, using contact information provided by the State. The RC will provide information on the patient, date of service, and type of service and notify the provider that a written request is forthcoming. The RC will verify the provider's name, phone number, and mailing address where medical records can be obtained and determine to whom the letter should be addressed. The RC will also determine the preferred method for the request (fax or first class mail). If the RC is unable to verify the provider information on the State's claim files after using other means (e.g., internet, directory assistance), the RC will contact the State to obtain more current provider information.

50.2 Initial Medical Record Request

If the fax method is preferred, the RC will fax the PERM initial request letter package, with cover letter to the fax number provided within one hour of the telephone call or as reasonable during high volume times and constraints. If mail delivery is preferred, the RC will send the initial request letter package to the point of contact at the confirmed address via standard USPS first class delivery within one business day of the telephone contact.

The initial medical record request letter includes a brief introduction to PERM and contact information for RC representatives working on collection of medical records. The initial letter includes language informing the provider that a claim submitted by, or on behalf of, the provider was randomly selected for review and indicates that the State may seek recoveries for claims in

which medical records are not received by the RC in a timely manner. The letter also describes CMS' authority to collect medical records under the Social Security Act; that CMS and its contractors will comply with the Privacy Act and the regulations at 45 CFR parts 160 and 164, and provide specific reference to the HIPAA standards, including language that the release of medical records and patient information is not a violation of HIPAA standards. The RC customer service representative's telephone number and the provider's State Medicaid representative's telephone number is included if the provider requires additional information or has questions.

The letter package includes a claim summary with details for the provider to identify the appropriate record (e.g., the beneficiary name; date of service; diagnostic code (ICD-9-CM); service code (CPT, HCPCS or prescription number); and total amount of claim or total amount for service). The letter package also includes a PERM Fax Cover Sheet that describes the specific documentation being requested (a request list is attached to the initial request letter) and asks that all medical documentation pertaining to the specific service rendered be submitted to the RC. Each claim is assigned a specific claim category and claim category specific components (i.e., history and physical, plan of care etc.) of records are listed on the record documentation request list. Finally, the letter indicates that the provider has 75 calendar days from the issue date of the letter to provide the requested medical record to the RC. The last enclosure of the letter package includes instructions for providers' submission of medical records to the RC. Records may be submitted by the United States Postal Service, a toll free fax number, CD, or electronic submission of Medical Documentation (eMD) to the RC. For more information about esMD, see www.cms.gov/esMD.

50.3 Follow-up Medical Record Requests

The RC will contact each provider who has not submitted the requested record information by telephone. The RC will make up to three additional calls at 30, 45 and 60 calendar days from the initial request and send up to three additional letters that remind the provider of the date on which the 75-day clock will expire.

If the provider does not submit the requested information by the deadline, the RC sends a final letter that contains the detailed request information. The letter also informs the provider that failure to submit the requested medical record resulted in a PERM error and that a notice of the error will be submitted to State officials who may seek recoveries for claims in which medical records are not received by the RC in a timely manner.

50.4 Follow-up for Incomplete Documentation

The RC will process additional documentation requests when incomplete documentation is received from the provider. Once a medical reviewer identifies that there is incomplete documentation for a specific service, he or she will note specifically what documentation is necessary to complete the review and the RC will contact the provider by phone and send a letter to request the additional documentation. If the additional documentation has not been received within seven calendar days from the provider, a reminder call to the provider is made and a reminder letter is sent. If the additional documentation is not received from the provider within 14 calendar days, it will be counted as an insufficient documentation (MR2) error.

If the provider does not submit the requested information by the deadline, the RC sends a final letter that contains the detailed information request. The letter also informs the provider that failure to submit the requested medical record resulted in a PERM error and that a notice will be submitted to State officials of the error who may seek recoveries for claims in which medical records are not received by the RC in a timely manner.

50.5 Late Documentation Policy

In cases where the RC receives no documentation from the provider after 75 days have passed since the initial request, the RC will consider the case to be a no documentation error. The RC will consider any documentation received after the 75th day to be “late documentation.”

If the RC determines that the documentation submitted by the provider is insufficient to make a determination about whether or not the claim should have been paid, they will request additional documentation from the provider. Providers have 14 calendar days to submit the additional documentation to CMS. Additional documentation received after the 15th day will also be considered “late documentation.”

If the RC receives late documentation prior to the cycle cut-off date for error rate calculation and reporting purposes (generally the second July 15 of a measurement cycle), it will review the records and, if justified, revise the error finding.

If late documentation is received after the cycle cut-off date, the documentation will be reviewed under continued processing only if the request qualifies for continued processing (still within the 75 day timeframe for original requests and within the 14 day timeframe for additional documentation requests).

50.6 Policy for Handling Lost or Destroyed Documentation

The PERM measurement involves the review of documentation in support of paid FFS claims in the Medicaid and CHIP programs. Providers are contacted and requested to submit documentation for review of their claims. A provider may be unable to provide documentation due to its loss or destruction from a natural disaster such as a flood, hurricane, earthquake or tornado, and in cases of destruction by fire. In the event of a Federal Emergency Management Agency (FEMA) declared disaster, the SC will drop the claim from the sample, and replace the claim with another randomly sampled claim if time allows. Determinations in the event of a fire will be made on a case-by-case basis.

50.6.1 Provider Attestation

The PERM RC sends requests for medical records/documentation to a provider to complete a medical review. If a provider is not able to supply the documentation due to loss or destruction from a disaster, the provider should submit an attestation statement by fax or mail to the RC within 75 days of the date of the initial written request for documentation from the RC.

50.6.2 Re-Sampling or Excluding Claims

In the event a provider’s documentation has been lost or destroyed in a FEMA declared disaster, the sampled claim will be replaced with another randomly sampled claim from that State’s

universe for the PERM review. In the event re-sampling is no longer possible due to timeline constraints, the SC will discard the claim(s) from the sample.

50.7 Policy for Providers Under Fraud Investigation

For claims selected in the PERM sample where the provider is under fraud investigation, the State may notify the RC that the record for a specific provider is not available due to the investigations and the RC will stop all requests for associated records in the sample. Since the record will not be submitted for review, the finding will be an error (MR1 – no documentation) and reported as an error in the final findings.

60. Data Processing Reviews

A data processing error is an error resulting in an overpayment or underpayment that is determined from a review of the payment and other information available in the State's Medicaid Management Information System, related systems, or outside sources of provider verification.

The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with the State's documented policies, is the dollar measure of the payment error.

Data processing (DP) errors include, but are not limited to the following:

- Payment for duplicate items
- Payment for non-covered services including provider enrollment errors
- Payment for fee-for-service claims for managed care services
- Payment for services that should have been paid by a third party but were inappropriately paid by Medicaid or CHIP
- Pricing errors
- Logic edit errors
- Data entry errors
- Managed care rate cell errors
- Managed care payment errors

All FFS and managed care claims are subject to DP review. For FFS claims sampled at the header level, the data processing review includes examining all line items in each claim to validate that it was processed correctly. For FFS claims sampled at the line level, the data processing review includes examining the payment for the line that was sampled. DP reviews for managed care payments check for the accuracy of the processing of the capitation payment or premium.

The RC will request data processing manuals, systems navigational tools, and pricing guides prior to and during the DP orientation visit if not available on the States' websites. Some DP review tools may be gathered during the first on-site review or during remote reviews as needs or exceptions are identified.

60.1 Basic FFS Data Processing Review Components

The following elements are reviewed during the data processing FFS review:

60.1.1 Verification of Beneficiary Information

In order for the RC to determine that the beneficiary was eligible for payment of the services under review, the following beneficiary information is reviewed:

- Date of birth/age
- Date of death
- Citizenship status
- City/zip code if needed to determine managed care status
- County of residence
- Sex/gender
- Beneficiary ID
- Living arrangements (home, institution, group home, other)
- Patient liability
- Patient level of care, if applicable
- Program eligibility (aid category/benefit plan) and effective dates (relative to dates of service) reviewed in MMIS system and may also be reviewed in the State eligibility system or through reports from that system
- Beneficiary residency or population requirement for enrolling in a managed care plan, or living in a mandatory managed care geographical area

60.1.2 Verification of Third Payer Liability (TPL) Payment Information

TPL and Medicare information is reviewed to determine whether another source was available to cover the service, and if so, whether it was considered in accordance with the State's TPL policy (cost avoidance, pay and chase). Information review includes:

- Medicare eligibility – Parts, A, B, and D with dates of eligibility
- Other TPL information including coverage dates and covered services

60.1.3 Verification of Provider Eligibility

In order to verify that the provider(s) (including billing, attending/servicing and ordering/referring providers) were registered and eligible to provide and bill for the services under review, the following provider information is reviewed:

- Provider name
- Provider number
- Provider registration/enrollment
- Provider license, if required

- CLIA certification, if required
- Provider type and specialty
- Provider and service location
- Provider sanction/suspension periods, including verifying a provider is not listed on the
- Office of Inspector General (OIG) excluded providers list (LEIE)
- State compliance with provider risk-based screening for new providers enrolled after 3/24/11

60.1.4 Verification of Accurate Claim Payment

In order to determine that the payment for a covered service was accurately calculated and paid, the following elements are reviewed:

- Claim filing date and filing timelines applicable to that claim/provider type
- Service coverage policies are checked to assure the service provided includes a prior authorization (PA) if required, the PA limits (dollar amount, number of units and dates in effect) have not been exceeded by the paid amount, and the proper fee schedule in effect was used for the date of service
- Duplicate payment history
- Adjustments to the sampled claim
- State compliance with HIPAA electronic claims standards

Note that in order to complete these aspects of the review, the reviewer may need access to screens containing information on National Drug Codes (NDC), revenue codes, procedure codes, payment rates, and pricing schedules (e.g., DRG, per diem, max fee, provider specific), for all types of claims. The reviewer may need to access rates for older dates of service and if the State makes retroactive rate adjustments it will be necessary to access the rates that were in effect for the DOS on the date that the claim under review was paid. Information about how the State calculates each type of payment may be required. If the State processes payments for “sister agencies” that receive pass-through FFP at the federal match rate, (i.e., Medicaid in public schools, mental health) this information needs to be identified so pricing can be accurately determined. The reviewer may need access to other claims in the system in order to conduct a check for duplicates. If the provider filed a hard copy claim, access to the scanned image of the claim as well as the system information is required. Finally, the reviewer may need access to tables that explain codes used in the system (if this is not contained in the system help).

60.2 Basic Managed Care Data Processing Review Components

60.2.1 Verification of Beneficiary Information

In order for the RC to determine that the beneficiary was eligible for payment of the services under review, the following beneficiary information is reviewed:

- Date of birth/age
- Date of death

- Citizenship status
- City/zip code (if needed to determine managed care status)
- County of residence
- Sex/gender
- Beneficiary ID
- Living arrangements (home, institution, group home, other)
- Patient liability
- Patient level of care, if applicable
- Program eligibility (aid category/benefit plan) and effective dates (relative to dates of service) reviewed in MMIS system and may also be reviewed in the State eligibility system or through reports from that system
- Beneficiary residency or population requirement for enrolling in a managed care plan, or living in a mandatory managed care geographical area

60.2.2 Health Plan Contracts

In order to determine that the capitation paid was correct, the contractor reviews the terms of the health plan contract to determine the following:

- Capitation rates in effect for coverage month
- Terms of the contract regarding pro-ration of capitation for births and deaths
- Population and service carve-outs
- Reinsurance or stop loss terms, if applicable
- Geographic service areas covered by each plan under contract
- Other contract terms that could affect proper payment

60.2.3 Correct Payment

The contractor will determine whether the beneficiary is in the correct rate cell based on State policies, the health plan contract and whether the proper payment was made based on that rate cell.

60.2.4 Other

The contractor will check for duplicate payments made for the same beneficiary for the same month and also document any adjustments made within 60 days of the sampled payment date.

60.3 Data Processing Error Codes

DP 1 – Duplicate Claim: The sampled line item/claim or capitation payment is an exact duplicate of another line item/claim or capitation payment that was previously paid (for example, same patient, same provider or health plan, same date of service, same procedure code, and same modifier). Conflict duplicates may also be identified.

DP 2 – Non-covered service/Recipient: The State policy indicates that the service is not payable by the Medicaid or CHIP programs and/or the beneficiary is not in the coverage category for that service.

DP 3 – FFS claim for a managed care service: The beneficiary is enrolled in a managed care organization that should have covered the service, but the sampled service was inappropriately paid by the Medicaid or CHIP FFS component.

DP 4 – Third-Party Liability error: The service should have been paid by a third party and was inappropriately paid by Medicaid or CHIP.

DP 5 – Pricing error: Payment for the service does not correspond with the pricing schedule on file and in effect for the date of service.

DP 6 – Logic edit error: A system edit was not in place based on policy or a system edit was in place but was not working correctly and the line item/claim was paid (for example, incompatibility between gender and procedure).

DP 7 – Data entry error: A line item/claim is in error due to clerical errors in the data entry of the claim.

DP 8 – Managed care rate cell error: The beneficiary was enrolled in managed care and payment was made, but for the wrong rate cell.

DP 9 – Paid Incorrect Managed Care Rate: The beneficiary was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.

DP10 – Provider Information/Enrollment error: These errors consist of errors for providers who have not been enrolled in Medicaid or CHIP according to federal regulations and State policy; missing information on attending or rendering providers required to be on institutional claims; and/or missing information on referring/ordering providers when required for a specific service type.

DP 11 – Claims Filed Untimely error: The claim was not filed within the timely filing requirements for the date of service in accordance with federal regulations and State guidelines.

DP 12 – Administrative/other error: A payment error was discovered during a data processing review but the error was not a DP1 – DP11 error.

DTD – Data Processing Technical Deficiency: A deficiency was found during data processing review that did not result in a payment error.

C1 - No Error: The claim was reviewed and no errors or deficiencies were found.

70. Medical Record Reviews

A medical review error is an error resulting in an overpayment or underpayment that is determined from a review of the provider's medical record or other documentation supporting the service(s) claimed, Code of Federal Regulations that are applicable to conditions of payment, the State's written policies, and a comparison between the documentation and written policies and the information presented on the claim.

The dollar measure of the payment error is the difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with 42 CFR 440 to 484.55 of the Code of Federal Regulations that are applicable to conditions of payment and the State's documented policies.

Medical review errors include, but are not limited to the following:

- Lack of documentation
- Incomplete documentation
- Procedure coding error
- Diagnosis coding error
- Unbundling
- Number of unit error
- Medically unnecessary service
- Policy violation
- Inadequate Documentation
- Administrative/Other error
- Medical Technical Deficiency

Medical review is conducted on all sampled FFS claims, with the exception of Medicare Part A and Part B premiums, primary care case management payments, aggregate payments, other PERM fixed payments, denied claims, and zero-paid claims. Medical review may be required for denied claims if the claim was denied for medical necessity or other reason verifiable only through review of the medical record. The medical review is exclusive of the data processing review. States can track medical review findings using the PERM RC's website. The homepage of the PERM RC's website includes a user's guide.

70.1 Basic Medical Review Components

The purpose of medical review is to determine if each sampled claim was paid correctly. This determination is made based on information in the medical record and the paid claim. Although in most cases individual line items will be sampled, it may be necessary to review all items on a claim in order to determine the accuracy of the individual line (reviewers will not record errors associated with lines on a claim that were not part of the sample).

The mechanics of the medical review (e.g., documentation that is requested, policies reviewed) will vary by service type. In general, review procedures will map closely to the PERM claim categories, although in some cases (e.g., denied claims), specific review procedures may be required. The PERM claim categories for medical review are listed below.

Claim Category 1: Hospital (non-mental health)

- Acute Inpatient
- Long Term Acute
- Acute Inpatient Rehabilitation

Claim Category 2: Psychiatric, Mental Health, and Behavioral Health Services

- Inpatient and outpatient psychological, psychiatric and behavioral health services
- Drug and alcohol inpatient and outpatient services
- Group Homes

Claim Category 3: Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF)

- Nursing home and convalescent centers
- Intermediate Care Facilities (ICF)
- Chronic care hospitals

Claim Category 4: Intermediate Care Facilities (ICF) for Intellectually Disabled and ICF Group Homes

Claim Category 5: Clinic Services

- Federally Qualified Health Centers (FQHC)
- Indian Health Service Outpatient
- Rural Health Clinic (RHC)

Claim Category 6: Physicians, Physician Clinics, and Other Licensed Practitioners' Services (includes Nurse Midwife and Midwife services)

- Physicians and other licensed practitioners' services
- Physician clinic services

Claim Category 7: Dental and Oral Surgery Services

Claim Category 8: Prescribed Drugs

Claim Category 9: Home Health Services

- Home health agency services and medical supplies
- Equipment and appliances through the Agency

Claim Category 10: Personal Support Services

- Personal care services
- Personal care attendant, aide, homemaker services and respite care
- Targeted Case Management services
- Private Duty Nursing
- Meal delivery services

Claim Category 11: Hospice Services

- Services provided in the home or in a nursing facility, hospital, or hospice facility

Claim Category 12: Therapies, Hearing, Vision, and Rehabilitation Services

- Therapies: physical, occupation, and respiratory
- Services for speech, hearing, and language disorders
- Necessary supplies and equipment
- Ophthalmology, Optometry and Optical Services

Claim Category 13: Day Habilitation and Waiver Programs, Adult Day Care, Foster Care and School Based Services

Claim Category 14: Laboratory, X-ray and Imaging Services

Claim Category 15: Outpatient Hospital Services

- Outpatient Hospital Services
- Outpatient Emergency Services

Claim Category 16: Durable Medical Equipment (DME) and supplies

- Prosthetic and orthopedic devices
- Other medical supplies/equipment
- Environmental modifications

Claim Category 17: Transportation and Accommodations

Claim Category 99: Unknown

The following claim categories do not require medical review:

Claim Category 18: Denied Claims

Claim Category 19: Medicare Crossover Claims

Claim Category 30: Capitated/Fixed Payment Claims

- Primary Care Case Management
- Medicare Premiums
- Health Insurance Premium Payments (HIPPP)

Claim Category 50: Managed Care Payments

70.2 Process for Conducting the Medical Review

A comprehensive medical review will be performed on each sampled unit (full claim or line item) for which medical records are received. This review includes reviewing medical record documentation, reviewing Federal regulation and State-specific guidelines and policies related to the claim, and determining whether the service was medically necessary, reasonable, provided in the appropriate setting, billed correctly, and coded accurately.

Claims will be reviewed for medical errors using the PERM review process in accordance with State-specific policies (i.e., if a certain aspect of the recommended review process outlined here does not apply in a given State, then it does not have to be followed). The reviewer is responsible for using all applicable documents, references, medical necessity guidelines, and their clinical review judgment to determine if the service was medically necessary and paid in accordance with required policies.

Medical review is considered complete when 100 percent of the amount paid is found to be in error. No further review is necessary. The RC system will populate either the nurse or coder findings automatically to mirror the original findings when 100 percent error has been recorded by the other component.

70.2.1 Verification of Documentation Sufficiency

In order for the RC to determine whether appropriate and sufficient documentation was received, the following information is evaluated:

- Was all documentation received to support the service billed in accordance with State policy documentation requirements?
- Does documentation support the requested sampling unit?
- Does documentation support the dates of service?
- Are signed physician orders included?
- Are approved certifications/re-certifications included (if required by State policy)?

The original medical record request lists the specific supporting documentation that should be sent for each claim category.

70.2.2 Verification of Service Provision in Accordance with State Policy

The policy review includes review of the applicable State-specific Medicaid or CHIP policy related to the service that is under review. The procedure or service documented in the medical

record is reviewed to determine if the service is a covered service under the State's policy and to determine if there are any service limitations applicable to the covered service (e.g., units, quantities) and if the service was provided within those limitations. Source documentation for the review will include documented State policies; including non-covered benefit limitations, provider manuals, and the Code of Federal Regulations.

70.2.3 Confirmation of Medical Necessity of Service

The medical necessity review includes review of the medical record to determine if the service provided was consistent with the symptoms or diagnosis under treatment. In addition, the medical review may also involve a contextual claim review of other services provided to determine the pattern and feasibility of the service being reviewed. The reviewer may need to review the entire medical record to determine if the sampled service was medically necessary.

Source documentation for the review will include documented State policies, including medical necessity documentation guidelines utilized by State (e.g., McKesson InterQual, Milliman Care Guidelines, or internal State guidelines), provider manuals, and the Code of Federal Regulations.

70.2.4 Determination of Whether the Service Rendered Matches the Service Codes Billed and Paid

The coding validation of the medical review may involve confirmation of the diagnosis recorded by the provider and its relevance to the billed procedure code. The coding review includes reading the medical record documentation and applying applicable coding guidelines to assure that the code billed and paid is the most appropriate code and level of code for the service rendered and that multiple codes were not assigned when only one code is appropriate (unbundling). For long-term care and prescribed drugs claim categories, coding reviews are not performed.

In order for the RC to determine whether appropriate and sufficient documentation was received, the following information is evaluated:

- Does the code billed agree with documentation in the medical record?
- Are procedure codes unbundled?
- Does billed code agree with diagnosis?
- Is diagnosis code appropriate (if relevant to payment)?
- Is diagnosis included in DRG (if relevant to payment)?
- Would another procedure code be more appropriate?

70.2.5 Verification of Appropriate Physician Certification

For long-term care, inpatient hospital services, and home health care, the review determines whether there was a signed physician certification, if required by State policy.

70.3 Special Rules for Medical Review

70.3.1 Underpayments

If reviewers note a discrepancy between the number of units billed and the number of units provided, they should verify whether there was a written State policy in effect at the time the payment was made for reimbursing only the amount billed up to the maximum allowable amount, and cite no error if there is a policy, or cite an error if there is no policy.

70.3.2 Date of Service

Claims with incorrect date of service (DOS) are medical technical deficiencies (MTD) if all of the following apply:

- If all the other details of the claim are correct (the medical record matches the claims details)
- If the DOS does not deviate by more than seven calendar days (the medical record shows the DOS is no more than seven calendar days before or after the billed DOS)
- The medical record supports the charges billed
- For per diem hospital claims, the record reflects the same number of days as was billed and rate schedules remain the same

These claims should be coded as a Medical Technical Deficiency (MTD) with \$0.00 in error.

Claims with incorrect DOS are payment errors if all of the following apply:

- Other details of the claim are incorrect (the medical record does not match the claims details)
- The DOS deviates by more than seven calendar days (the medical record shows the DOS are more than seven calendar days before or after the billed DOS)
- The medical record does not support the charges billed (e.g., procedure/treatment not performed but billed, wrong number of units billed)

These claims should be coded with the appropriate medical review error code and with the appropriate payment amount in error.

For home and community based services, services are often provided on a daily basis, therefore, claims with incorrect DOS are payment errors if all of the following apply:

- The DOS does not match the claim
- The medical record does not support the charges billed (e.g., procedure/treatment not performed but billed, wrong number of units billed)

These claims should be coded with the appropriate medical review error code and with the appropriate payment amount in error.

70.3.3 Level of Care

If the medical review indicates the beneficiary did not meet medical necessity for inpatient hospitalization because the care could have been provided and billed at an outpatient observation level, an error will be determined for 100% of the paid amount. States will need to request a Difference Resolution to re-price this as a partial error. When a State's Medicaid or CHIP program does not cover observation status, and outpatient observation level of care was medically necessary, no finding of improper payment is made.

70.4 Medical Review Error Codes

MR 1 – No documentation: The provider did not respond to the request for records within the required timeframe.

MR 2 – Incomplete documentation: There is not enough documentation to support the service.

MR 3 – Procedure coding error: The procedure was performed but billed using an incorrect procedure code and the result affected the payment amount.

MR 4 – Diagnosis coding error: According to the medical record, the diagnosis was incorrect and resulted in a payment error – as in a Diagnosis Related Group (DRG) error.

MR 5 – Unbundling: The provider separately billed and was paid for the separate components of a procedure code when only one inclusive procedure code should have been billed and paid.

MR 6 – Number of unit(s) error: The incorrect number of units was billed for a particular procedure/service, National Drug Code (NDC) units, or revenue code. This does not include claims where the provider billed for less than the allowable amount, as provided for in written State policy.

MR 7 – Medically unnecessary service: The service was medically unnecessary based upon the documentation of the patient's condition in the medical record in accordance with written State policies and procedures related to medical necessity.

MR 8 – Policy violation: A policy is in place regarding the service or procedure performed and medical review indicates that the service or procedure is not in agreement with the documented policy.

MR9 – Inadequate Documentation error: The required forms and documents are present, but are inadequately completed to assure that the services were provided in accordance with policy or regulation.

MR 10 – Administrative/Other medical review error: A payment error was determined by the medical review but does not fit into one of the other medical review error categories, including State-specific, non-covered services.

MTD – Medical Technical Deficiency: A deficiency was found during medical review that did not result in a payment error.

C1 - No Error: The claim was reviewed and no errors or deficiencies were found.

In some cases, it may be difficult to distinguish between insufficient documentation errors (MR 2) and policy violation errors (MR 8). Exhibit 6 outlines examples of the guidelines the RC will follow to assign these errors properly and consistently.

Exhibit 6. Assignment of MR 2 and MR 8 Errors

Error Code	Qualifier (1)	Qualifier (2)	Qualifier (3)
MR 2 – Insufficient Documentation Error	Provider did not supply sufficient documentation to support medical necessity of the claim.	Provider did not supply a valid prescription.	Medical records do not contain the daily documentation of tasks performed on DOS billed.
MR 8 – Policy Violation	Documentation does not meet State policy requirements for conditions of payment for the service or procedure performed.	Prescription refill occurred beyond one year from the date of issuance of the original.	Documentation of the home delivered meal services does not meet the State requirements for conditions of payment.

80. Difference Resolution and CMS Appeals Processes

There are potentially two levels of PERM error determination dispute that States may pursue, the difference resolution process and the CMS appeals process. These processes afford States the opportunity to overturn PERM error-determinations. The dispute processes collectively provide States with due process for disputing and overturning PERM error-determinations.

80.1 Difference Resolution Process

The difference resolution process is the first level of PERM error-determination dispute and provides the means by which States can dispute the RC’s medical review and data processing error findings. States that dispute PERM error-determinations through the dispute resolution process are eligible to appeal the difference resolution determination to CMS. States that do not pursue difference resolution are not permitted to appeal PERM error- determinations to CMS.

80.1.1 Notification of Difference Resolution Rights

The difference resolution process occurs after the RC publishes the PERM sampling unit disposition report of claims review findings on its website on the 15th and 30th of each month. States should review this report and a copy of the documentation submitted to the RC to determine whether they dispute the error-determinations cited in the report. Instructions for requesting difference resolution through the RC’s website are located in the RC Website User Guide.

80.1.2 Eligibility for Difference Resolution

The following terms and conditions apply to the PERM difference resolution process:

- Most medical review and data processing review errors are eligible for difference resolution

- PERM error-determinations that occur because records were not submitted to the RC (so-called “no documentation” errors) are not eligible for difference resolution
- States have 20 business days to request a difference resolution after receiving the error notice on the Sampling Unit Disposition report.
- A request for difference resolution must contain, at a minimum:
 - The factual basis for why a State disputes the RC’s error-determination
 - Valid evidence directly related to the error determination to support a State’s position that the claim in question (i.e., the error-determination) was properly paid

80.1.3 Difference Resolution Review Process

States must file a request for difference resolution through the RC’s website within 20 business days of the date the State’s PERM sampling unit disposition report was posted on the RC’s website. The RC reviews the request for difference resolution and makes a determination—upholding, modifying, or overturning the initial PERM error determination. The RC has 15 days from the date it receives a request for difference resolution to issue its difference resolution determination. States are notified by email when the RC has posted the difference resolution decision to the RC website.

Error-determinations not challenged by a State are included in the error rate calculation. Error-determinations challenged by a State and upheld by the RC are included in the error rate calculation unless a request for CMS appeal is filed by the State. Error-determinations overturned by the RC are not included in the error rate calculation.

80.1.4 Re-Pricing Partial Errors During Difference Resolution

During medical review conducted for the PERM program, sampled claims’ medical records are reviewed for medical necessity, coding validation and accuracy of payment. In some cases, an error finding may be made (e.g., procedure coding error, number of units error) that would initially be reported as 100% error but should only result in a portion of the payment being in error (partial error). The State is required to re-price partial errors using the DR process. The claim must be “re-priced” by the State under DR so that written re-pricing evidence can be submitted to the RC and the correct error amount can be calculated.

Types of errors that may partially affect payment include:

- MR 3 - Procedure coding error
- MR 4 - Diagnosis coding error
- MR 5 - Unbundling
- MR 6 - Incorrect number of units billed
- MR 9 - Administrative/Other

In addition to the above error codes assigned, the partial errors that need to be re-priced through DR will be noted on the RC’s web site under the list of reviews available for DR.

For partial medical review errors, the State can review the error amounts assigned to determine if the claim needs to be re-priced at the DR stage of review. State research of the correct payment amount can begin when the State receives the advanced error notification to allow time to gather evidence for re-pricing and to prepare for the DR opportunity.

The State has the opportunity to re-price claims with partial errors during the DR process. The date of the SUD report starts the filing timeline for a DR request. For partial medical review errors, if the State disagrees with the error finding, then it should submit records to dispute the error. If the State agrees with the error finding, but not the 100% error amount, the State must file a DR request in order to allow re-pricing and for the RC to correct the error amount. Written evidence must be supplied to the RC to re-price partial errors such as fee schedules, screen prints, etc. that would substantiate how the correct pricing amount was determined. The State will have 20 business days to file a DR and supply documentation to support their position and evidence of re-pricing needed for partial errors.

When the State supplies the re-priced amount, then the amount in error is calculated by taking the amount paid minus the amount that should have been paid. If the result is a positive number (less should have been paid), then the amount in error is an overpayment. If the result is a negative number (more should have been paid), then the amount in error is an underpayment. If the State does not provide a re-priced amount, then the error will be 100 percent of the paid amount for that sampling unit. If the documentation is not provided during DR or if the State does not request a DR, the full amount of the claim will remain as the error amount.

80.2 State Appeal to CMS

The CMS appeal process is the second level of PERM error-determination dispute and provides the means by which a State can appeal the RC's difference resolution determination to CMS. A State may only appeal PERM error-determinations upheld by the RC.

80.2.1 Notification of CMS Appeal Rights

The RC posts the difference resolution determination to the RC's website and notifies States of the difference resolution determination by way of electronic notification (email). This notification also describes a State's appeal rights.

80.2.2 CMS Appeal Eligibility

The following terms and conditions apply to the CMS appeal process:

- A State must first dispute the PERM error determination through the PERM difference resolution process
- A State must file its request for CMS appeal through the RC website within 10 business days of receiving the difference resolution determination from the RC

80.2.3 CMS Appeal Process

Upon receiving a request for CMS appeal from a State, CMS will have access to the entire sampling unit record. The sampling unit record is a case file comprised of the following documents:

- A copy of the original PERM claim
- All medical records reviewed by the RC
- State policies pertaining to the claim
- Applicable screen shots (if data processing error being appealed)
- The RC's review notes
- A State's written arguments as presented during the difference resolution proceedings
- A State's written arguments as presented during the appeal request

CMS designates a review panel of PERM clinical and policy experts to conduct the appeal proceedings. The CMS review panel is limited to the review of the medical record that was reviewed before the PERM difference resolution contractor. CMS will post their decision on the RC's website within 45 days of receiving a State appeal and States will be notified through email when an appeal is completed. The decision of the CMS review panel is final and binding on a State that requests CMS appeal.

Error-determinations upheld by the CMS appeal review panel are included in the error rate calculation. Error-determinations that are overturned by the CMS appeal review panel are not included in the error rate calculation.

Note that if an error was found in both the data processing review and medical review for a specific claim, the total error amount reported cannot exceed the total paid amount for the claim.

80.2.4 Receipt of Additional Documentation

If a State pursuing CMS appeal submits documentation to CMS that was not submitted to the RC during initial review or difference resolution, the CMS appeal case is stopped and the administrative appeal process ends. CMS sends the new documentation to the RC for re-review of the claim.

90. Errors and Error Rate Calculation

In determining a PERM error rate at the individual State level, at the national level, and for any program, the methodology is identical: the PERM error rate is the ratio of estimated improper payments to estimated total payments.

Improper payments are determined by the appropriate medical, data processing, and eligibility reviews, and are simply the absolute dollar value of the improper payment. An improper payment is generally the difference between what *was* paid and what *should have been* paid. "Estimated" payments are used in the calculation because only a sample of payments or cases is reviewed. The total improper payments and total payments are estimated by extrapolating the sample errors

and sample payments to the universe based on the appropriate sampling frequencies (we use the term “estimated” to describe the extrapolated figures).

90.1 Cycle Cut-Off

Error rates will be calculated based on information received from States/providers by the cycle cut-off date. Typically, the cycle cut-off date is the second July 15 of a measurement cycle. However, the cycle manager may push back the cycle cut-off date depending on the progress of the cycle.

The RC will review documentation received by the cycle cut-off date and difference resolution/appeals requested by the cut-off date will be completed for error rate calculation.

Documentation received or difference resolution/appeals requested after the cycle cut-off date will not be included in error rate calculations. However, these instances may be eligible for continued processing.

90.2 Error Codes

See Exhibit 7 below for a summary of error codes for medical review, data processing review, and eligibility review.

Exhibit 7. PERM Error Codes

Medical Review Error Codes	Data Processing Review Error Codes
<i>C 1</i> Correct	<i>C 1</i> Correct
<i>MR 1</i> No documentation	<i>DP 1</i> Duplicate item
<i>MR 2</i> Incomplete documentation	<i>DP 2</i> Non-covered service/Recipient
<i>MR 3</i> Procedure coding error	<i>DP 3</i> FFS claim for a managed care service
<i>MR 4</i> Diagnosis coding error	<i>DP 4</i> Third-party liability
<i>MR 5</i> Unbundling	<i>DP 5</i> Pricing error
<i>MR 6</i> Number of unit(s) error	<i>DP 6</i> System Logic edit
<i>MR 7</i> Medically unnecessary service	<i>DP 7</i> Data entry error
<i>MR 8</i> Policy violation	<i>DP 8</i> Managed care rate cell error
<i>MR9</i> Inadequate Documentation	<i>DP 9</i> Paid incorrect managed care rate
<i>MR10</i> Administrative/Other	<i>DP 10</i> Provider Information/Enrollment
<i>MTD</i> Medical Technical Deficiency	<i>DP 11</i> Claim Filed Untimely
	<i>DP12</i> Administrative/Other
	<i>DTD</i> Data Processing Deficiency

90.2.1 Error Hierarchy

When errors are found to be 100 percent in error under medical review, a hierarchy is used to classify the final error code used for reporting. This hierarchy is applied to identify the one error

code that is most responsible for the incorrect payment since the total amount in error cannot exceed the paid amount. The following lists the error codes in order of priority:

MR 1 - No documentation submitted by provider. When notified that no record was submitted by the provider, the system will code the review findings as MR 1 in both the coding and nurse tables. This sampling unit would not be submitted for medical review. The amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit and recorded as an overpayment in both the nurse and coding tables. No difference resolution or appeal can be filed on these sampling units. A re-pricing request from the State is not needed for these sampling units.

MR 2 – Incomplete documentation. If additional documentation is requested from the provider by the nurse or coder, both sampling units will be marked by the system as pending additional documentation. If the provider does not supply it within 14 days, the amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit as an overpayment and the RC system will populate the findings as MR 2 in both the coding and nurse tables. If some additional documentation is submitted timely, but after review is still considered not complete, either the nurse or coder will code the findings as MR 2, and the other (nurse or coder) findings screen will be populated by the system as MR 2 and the review will be eliminated from the remaining workload queue. The amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit and recorded as an overpayment in both the nurse and coding tables. A re-pricing request from the State is not needed for these sampling units.

MR 8 – Policy violation. If the nurse or coder finds that the services provided were not in accordance with the State’s policies, the sampling unit will be coded as MR 8. Then the other (nurse or coder) screen will be coded as MR 8 by the system and the claim will be removed from the workload queue. The amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit and recorded as an overpayment in both the nurse and coding tables. A re-pricing request from the State is not needed for these sampling units.

MR 9 – Inadequate documentation. If the nurse or coder finds that the services provided were due to required forms and documents being present, but are inadequately completed to assure that the services were provided in accordance with policy or regulation, they will code the findings as MR 9 by the system and the claim will be removed from the workload queue. The amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit and recorded as an overpayment in both the nurse and coding tables. A re-pricing request from the State is not needed for these sampling units.

MR 7 – Not medically necessary. If the nurse finds that the sampling unit was not medically necessary, they will code the findings as MR 7. The findings table for the coder will also be populated by the system as MR 7. The amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit and recorded as an overpayment in both the nurse and coding tables. The sampling unit will be removed from further review. If the State does cover observation level of care and the hospital stay is not medically necessary, the MR7 may be a partial error. Under these conditions, re-pricing by the State may be necessary.

90.2.2 Multiple Errors on One Claim

The RC will reconcile all claims where more than one error has been identified under medical review before reporting the error to the State. The error code that is 100 percent in error (i.e., the greatest amount in error) will be selected and errors with partial error amounts on the same claim will be ignored. PERM error amounts cannot exceed the total paid amount of the claim.

90.3 Adjustments

As noted earlier, the dollar amount of error for PERM purposes is generally the difference between what *was* paid and what *should have been* paid. PERM uses the original paid date and original paid amount to determine what was paid, with the exception of any adjustments made within 60 days of the original paid date.

Adjustments made outside of the 60-day timeframe allowed under PERM are not considered in determining whether a payment error should be cited. The reviewer will determine if the payment was made correctly based on the policies in effect at the time of the payment and the State's compliance with its payment policies. That is, the reviewer compares the payment amount to the amount that should have been paid at the time payment was made. For example, if prices are changed retroactively but the changes are made outside of the 60-day adjustment timeframe, it is not an error *if the payment made was based on the pricing schedule on file at the time payment was made*. Thus, if a payment was made and then adjusted more than 60 days later because of a State-initiated adjustment that was required for programmatic reasons that are unrelated to payment errors, it should not be considered an error in the PERM review.

90.4 Claims Error Rate Calculation

CMS will calculate the claims error rates for each program. A total of three error rates will be calculated for Medicaid and CHIP.

- A FFS payment error rate
- A managed care payment error rate
- A combined FFS and managed care payment error rate (dollar weighted)

90.5 Eligibility Error Rate Calculation

No State-specific eligibility error rates will be calculated for FY 2014, FY 2015, FY 2016, and FY 2017. States will participate in the FY 2014 – 2017 eligibility pilots, as discussed above. For the purposes of the national Medicaid and CHIP error rates, State-specific eligibility rates will be held constant from the State's prior PERM cycle. In the proceeding sections, any reference to inclusion of State eligibility error rates refers to this prior cycle error rate.

90.6 State-Level Error Rate Calculation

States participating in PERM have up to four separate components:

- Medicaid fee-for-service (FFS)
- Medicaid managed care

- CHIP FFS
- CHIP managed care

Each component has its own universe and sample that are being measured. Because the payment components (i.e., FFS and managed care) utilize independent universes, the payment error rates are additive. Since the eligibility component does not utilize an independent universe, a correction factor is applied to estimate the total program error rate, under the assumption that eligibility errors are independent of the other types of errors.

The State-level error rate is estimated as:

$$\hat{R}_i = \frac{\hat{t}_{e_i}}{\hat{t}_{p_i}}$$

In the equation, \hat{R}_i is the estimated error rate for State i ; \hat{t}_{e_i} is the estimated dollars in error projected for State i and \hat{t}_{p_i} is the estimated total payments for State i . Then,

$$\hat{t}_{e_i} = \sum_{j=1}^8 \frac{M_{i,j}}{m_{i,j}} E_{i,j}$$

and

$$\hat{t}_{p_i} = \sum_{j=1}^8 \frac{M_{i,j}}{m_{i,j}} P_{i,j}$$

In these equations, $M_{i,j}$ is the number of items in the universe for State i in strata j and $m_{i,j}$ is the number of items in the sample for State i in stratum j . The ratio of items in the universe to items in the sample is the inverse of the sampling frequency. "Dollars in error" in the sample for stratum j and State i , denoted $E_{i,j}$, is weighted by the inverse of the sampling frequency to estimate dollars in error in the universe for that stratum. In this example, the total number of strata is eight.

For example, if there are 10,000 items in the universe in stratum j , and the sample size in j is 100 items, the weight for the dollars in error in the stratum j sample is 100 (or 10,000/100). The estimated total dollars in error are then added across each of the eight strata to obtain total dollars in error for the universe. Total payments are estimated in the same way, where $P_{i,j}$ is the total payments in the sample in stratum j for State i .

90.6.1 Combining Claims Review Error Rates across Program Areas

Combining the claims review error rates, i.e., combining the FFS and managed care error rate for Medicaid and the FFS and managed care error rate for CHIP, is relatively straightforward given that population payments are known. Note that CMS does not utilize true population payments in calculating State rates for each program area. The reason for this is two-fold. First, the combined

ratio estimator used allows for correction of possible bias if the sampled average payment amount differs from the universe average payment amount. If CMS utilized a combined ratio estimator to combine the program areas at the State-level, one program area that realized high sample average payment amount compared to the universe average would have too much influence in projections. Second, combining program area rates using the shares of expenditures as weights reduces the variance in the estimates from this source. Furthermore, following this method allows the same method for combining program area claims review rates at both the State and national level.

The following equations use the estimated State or national error rates and variances calculated in the previous two sections.

Let the overall claims review error rate for Medicaid or for CHIP can be defined as:

$$\hat{R}_C = \frac{t_{P_{FFS}} \hat{R}_{FFS} + t_{P_{MC}} \hat{R}_{MC} +}{t_p}$$

where

$$t_p = t_{P_{FFS}} + t_{P_{MC}} .$$

In this equations R is the error rate for FFS, managed care or combined (C), and t_p represents total payments for FFS, managed care, or the total, depending upon the subscript.

90.6.2 Eligibility Error Rate Claims data are associated with each of the sampled eligibility cases in the active case strata. The dollar value of eligibility errors assessed was based on the implications of the eligibility review for the validity of the claims associated with the case. For each State, the results of the review were projected to the universe in a manner analogous to that described above for the FFS and managed care errors.

A national eligibility error rate was calculated using the same method employed in the FFS and managed care calculations. It is based on calculating an eligibility error rate for each State, and combining these rates into an overall national rolling rate based on the expenditures for each State.

90.6.2 Combining Claims Error Rates and the Eligibility Error Rate

The claims rate and the eligibility rate are not mutually exclusive. Combining the two achieves a total, or combined, error rate which necessitates netting out the estimated overlap in projected error.

After combining the FFS and managed care components of each program into one overall claims error rate for Medicaid and one for CHIP, respectively, at the State and national levels, these rates are combined with the respective eligibility error rates for each program. The combination of the claims review rate and the eligibility rate will be referred to as the combined error rate. The estimated combined error rate is given by:

$$\hat{R}_T = \hat{R}_C + \hat{R}_E - \hat{R}_E \hat{R}_C$$

where

\hat{R}_T denotes the estimated Total, or Combined Error Rate

\hat{R}_C denotes the estimated Claims Error Rate

and

\hat{R}_E denotes the estimated Eligibility Error Rate

In practice, the fee-for-service (FFS) and managed care programs represent two distinct portions of the Medicaid universe. At both the State level and the national level, these rates for FFS and managed care can be combined using the “Separate Ratio Estimator” to produce an overall combined error rate for Medicaid.⁵ This is referred as the claims rate.

The formula to compute the overall Medicaid claims rate (for State and national) is as follows:

$$\begin{aligned}\hat{R}_{Medicaid} &= \frac{P_{MedicaidFFS} \hat{R}_{MedicaidFFS} + P_{MedicaidMC} \hat{R}_{MedicaidMC}}{P_{MedicaidFFS} + P_{MedicaidMC}} \\ &= S_{MedicaidFFS} \hat{R}_{MedicaidFFS} + S_{MedicaidMC} \hat{R}_{MedicaidMC}\end{aligned}\tag{1}$$

where,

$P_{MedicaidX}$ = Payment for Medicaid ‘X’ program area (FFS or managed care)

$\hat{R}_{MedicaidX}$ = Estimated error rate for the Medicaid ‘X’ program area (FFS or managed care)

$S_{MedicaidX}$ = Share of payment for the Medicaid ‘X’ program area (FFS or managed care)

90.6.3 Continued Processing

Continued processing occurs when a claim did not have time to go through the full PERM process before the cycle cut-off date. Examples include:

- Medical records for a claim received after the cycle cut-off date but within 75 days of the initial request for medical records
- An error cited before the cycle cut-off date, when the State’s allowable timeframe to request difference resolution and CMS appeal extended beyond the cut-off date

Claims will complete the PERM process through continued processing and CMS will recalculate a State’s error rate based on the continued processing results.

⁵ Cochran, W.G., Sampling Techniques. Third Edition. Wiley. 1977.

By PERM regulation, providers must submit medical documentation within 75 calendar days of the initial request from the RC or by the cycle cut-off date. Therefore, CMS will not accept any new documentation after the cycle cut-off date that is not part of continued processing. However, if a State has documentation to support that a claim previously called an error was correctly paid (e.g., successful provider appeal results, claim adjusted after PERM 60- day window), they can work with their CMS Regional Office financial contact to determine what adjustment to the expenditure reports is required for recovery purposes.

90.7 State-Specific Error Rate Recalculations

CMS will recalculate a State’s error rate under two circumstances:

- A portion of the State’s sampled claims underwent continued processing and errors were overturned/error amounts were changed
- A mistake made by the PERM contractor was identified

CMS will issue recalculated error rates to all States affected by continued processing once continued processing is complete for a cycle. A new State-specific sample size for any affected component will also be calculated based on the recalculated error rate.

A State’s error rate is factored into in the national rolling error rate for three years. Error rate recalculations will not be included in the first year error rate because the recalculations occur after this number is reported. However, State-specific error rate recalculations will be included in the next two years a State’s error rate is included in the rolling rate.

90.8 National Rolling Error Rate Calculation

To go from the error rates for individual States to a national rolling error rate, the most current data available from all 51 States is first aggregated. This data includes the 17 States in the most current sample, as well as samples from the previous two years. Each State is benchmarked to its reported payments from the year it was sampled. Using the State expenditures as weights guarantees that a State’s impact on the national rolling error rate is proportional to the size of its payment.

Then, the error and payment amounts by component are combined across all 51 States to calculate the national rolling component error rates for FFS, MC, and Eligibility. The component error rates are combined to form the overall national rolling error rate, following the same method as used in calculating the overall State error rates.

The formula for calculating each component error rate is as follows:

$$\hat{R}_T = \frac{\sum_{i=1}^{51} t_{p_i} \hat{R}_i}{t_p}$$

Where \hat{R}_T is the national rolling error rate, t_{p_i} is the total expenditure for State i, and \hat{R}_i is the estimated error rate for State i. The sum of the error amounts across all 51 States is then divided by t_p , which is the total national expenditure.

Note that there is no “^” over the State and national payment data. This means that they are not estimated from the sample. These are actual payment expenditures. Hence, the national rolling error rate has an intuitive interpretation as a weighted sum of the estimated State error rates, where the weights are shares of expenditures.

90.9 Cycle Error Rate Calculation

The cycle error rate is calculated using a similar method to the one used in calculating the national rolling error rate. The component error rates are calculated using the weighted sums of improper payments and total expenditures across the 17 cycle States. Then, the cycle error rate is calculated using the component error rates.

The formula for the 17 State component cycle error rate is as follows:

$$\hat{R}_H = \frac{\sum_{i=1}^{17} t_{p_i} \hat{R}_i}{t_h}$$

Where \hat{R}_H is the 17 State cycle error rate, t_{p_i} is the total expenditure for State i , \hat{R}_i is the estimated error rate for State i , and t_h is the total expenditure from the 17 States in the cycle.

100. Error Rate Targets

OMB guidance for implementing IPERIA requires CMS to set targets for future erroneous payment levels for Medicaid and CHIP. Provided CMS has estimated a baseline error rate for the program, CMS is required to include a target for the program’s future erroneous payment rates in the AFR. Targets must be lower than the most recent estimated error rate.

100.1 National Error Rate Targets

CMS sets targets for the official three-year rolling national program error rate. Target error rates are set three years out from the most recently published error rate and are negotiated by OMB, HHS, and CMS. Current error rate targets can be found in the HHS AFR and on paymentaccuracy.gov.

CMS reported the first baseline three-year rolling Medicaid error rate in the 2010 AFR and has published error rate targets for Medicaid. The first CHIP baseline error rate was published in the 2014 AFR and CMS is currently publishing the error rate targets for this program.

100.2 State-specific Error Rate Targets

The national Medicaid error rate is a compilation of State-specific error rates and, therefore, collaboration between CMS and the States is vital in achieving the national error rate target. CMS sets State-specific overall program and component error rate targets that allow CMS to collaborate with States to meet the national target.

When setting State-specific error rate targets, CMS asks States to reduce their component error rates by a fixed proportion relative to an “anchor” rate. The anchor rates are currently set at 1.5

percent for FFS and 1 percent for managed care. Each State must reduce the difference between the previous component error rate and the component anchor rate by 50 percent. States with component error rates in the previous measurement that are less than the anchor rates will be expected to achieve the same or better error rate in the next measurement period.

An example of how State-specific target error rates are calculated is shown in Exhibit 8 below:

Exhibit 8. Calculation of State-specific target error rates

	FFS	Managed Care	Overall Claims
FY 2013 Rate	5.1%	0.2%	3.7%
Anchor Rate	1.5%	1%	
Difference between FY2013 rate and anchor rate	3.6%	N/A (under anchor)	
50 percent of the difference	1.8%	N/A	
Target FY 2016 Rate	3.3%	0.2%	2.4%

State-specific targets for a given PERM cycle are available when State error rates are released from the previous PERM cycle.

CMS may consider suggested adjustments to component targets, given the overall State target does not increase. There are currently no penalties or rewards in place if States do or do not meet their error rate targets.

100.3 Error Rate Reporting

At the conclusion of each PERM cycle, State-specific reports are shared for each program (Medicaid and CHIP). The following reports are submitted to States, typically in November, once national error rates are published in the AFR.

- **Error rate notification letter:** The letter contains the official State program error rate, overall and by component (e.g., FFS, managed care) as well as sample sizes and error rate targets for the State’s next PERM cycle
- **Cycle summary reports:** The report contains analysis on the error findings for each component (e.g., FFS, managed care), including specific information on each error based on RC claim reviews

110. Corrective Action Process

Following each measurement cycle, the States included in the measurement are required to complete and submit a Corrective Action Plan (CAP) based on the errors found during the PERM process. States are required to submit a separate CAP for Medicaid and CHIP. CMS provides guidance to State contacts on the CAP process upon publishing of the PERM error rates and throughout the CAP development until the specified due date of the CAP. The specified due date is 90 calendar days after the date on which the State’s error rates are posted on the RC’s Website.

The CAP process involves analyzing findings from the PERM measurement, identifying root causes of errors, and developing corrective actions designed to reduce major error causes, trends

in errors or other vulnerabilities for purposes of reducing improper payments. The new CAP should also include an evaluation of the previous submitted CAP. Through the CAP process, States are able to take administrative actions to reduce errors which cause improper Medicaid and CHIP payments.

The process of implementation of the CAP must start no later than 90 calendar days after the State's receipt of the Medicaid and CHIP error rates. Each CAP is in effect for three fiscal years and is updated after the next cycle's measurement and subsequent CAP submission.

110.1 PERM CAP Team

The role of the CAP Team is to support the corrective action phase of the PERM program by analyzing error rate data for the purposes of reducing improper payments in Medicaid and CHIP through corrective actions taken at the Federal and State levels. The PERM CAP Team will maintain a partnership with the States in an effort to foster collaboration and gain State participation in establishing PERM State-level corrective actions. The CAP Team's primary responsibilities include working with the States to assist the States in the development, timely submission and implementation, and evaluation of previously submitted CAPs.

The CMS Region Office (RO) are invited to attend all calls scheduled by the Central Office PERM CAP team members (e.g., kick-off calls, State cycle summary call discussions, CAP evaluation, and other calls that are necessary and reasonable).

110.2 CAP Kick-off Call

In September, after the conclusion of the measurement review and prior to publishing the States' error rates on the website by the RC and in the AFR the PERM CAP Team will have an initial "CAP kick-off call" with all States in the measurement to discuss the corrective action process. Prior to the call several documents are forwarded to the State for review. These documents include a PowerPoint presentation explaining the CAP process, the October 2007 State Health Official (SHO) letter, comprehensive CAP instructions, and a "kick-off call" agenda. The States are encouraged to invite whomever they feel needs to be included in this kick off conference call.

110.2.1 Individual State Calls

The next contact with the State is in November after the official error rate has been released and the contractor has posted the States error rate on the RC's website. Individual State specific calls are made to the 17 States that were a part of the yearly measurement process to discuss the Cycle Summary Report which includes an Executive Summary and State-specific error analysis findings that are prepared by the contractors. The States are encouraged to invite whomever they feel needs to be included in this call.

110.2.2 State Forum Call

CMS provides each State in the CAP phase of the PERM program with the opportunity to have a "State Forum Call" in which CMS provides a conference call line for the States to use and discuss best practices as they relate to developing corrective actions. While CMS provides the conference call line, a State volunteer within the cycle facilitates the discussions amongst the

States. After the first State Forum Call, States may decide whether a second call is needed for further discussion.

110.3 Corrective Action Panel

The key to a successful CAP is the formulation of a corrective action panel. The panel in turn must encourage participation and commitment of top management to coordinate efforts across the agency and ensure participation of major department leaders.

Senior management could include managers responsible for policy and program development, field operations, research and statistics, finance, data processing, human resources (for staff development), and the legal department. These managers would comprise the corrective action panel. Leadership of the panel should rest with the State Medicaid or CHIP Director.

Responsibilities of the corrective action panel include:

- Providing insight on possible causes of errors
- Communicating the CAP progress to management and other stakeholders
- Developing strategies
- Making all major decisions on the planning, implementation and evaluation of corrective actions

110.4 Components of the Corrective Action Plan

CAPs are composed of five elements and required by regulation. The five elements are: data analysis, program analysis, corrective action planning, implementation and monitoring, and evaluation. States are required to submit a separate CAP for Medicaid and CHIP.

The CAP instructions are located on the PERM website under the CAP tab.

110.4.1 Data Analysis

Data analysis will now be performed for the State. The number of errors and dollars in error for each qualifier within the error category will be pre-populated in the CAP template by CMS. Space is provided for States to enter additional optional data analysis if they would like to add more information about the nature of the error. Data analysis enables the State to gain a more thorough understanding of the root cause of the errors, when the errors occurred, and who or what caused the error. For example, data analysis might identify that an error:

- Accounted for 10% of the total errors (5) identified during the medical records review
- Resulted in a total overpayment of \$100
- Occurred because the personal care assistant documentation was not maintained in accordance with State policy to support the 10 units of procedure code T1019 (Personal care services, per 15 minutes) for the date of service sampled

110.4.2 Program Analysis

This component is the most critical part of the corrective action process where States must review the findings of the data analysis to determine the specific causes of the errors. States must identify the root causes of the errors to determine the best solutions (e.g., why providers are not complying with medical record requests). The States may need to analyze the agency's operational policies and procedures and identify those policies and/or procedures that are more prone to contribute to errors, e.g., policies are unclear, lack of operational oversight at the local level.

Program analysis, along with data analysis, provides the framework for evaluating relevant information to determine the facts and causal factors in order to develop the most appropriate, timely corrective actions to resolve the finding and prevent recurrence. If errors look to have been caused by inadequate training, then the State should take actions to strengthen its training programs. This could be accomplished by worker interviews, questionnaires, policy reviews, and conferences with local managers, etc.

States must explain how its program analysis activities address 100 % of the payment and eligibility error-types. Although States may not be inclined to plan corrective actions for one-time error situations, such as human error, or corrective actions which are not cost-effective, States must nevertheless at least address the fact that this is its position.

States should describe how program analysis activities go beyond the surface cause (nature) of an error and looks to the root cause and describes actions that the State is taking to meet or exceed its PERM error-rate target, as specified by CMS. States should discuss why a particular program/operational procedure caused the specific error and identify the root causes of errors.

All errors should be addressed including deficiencies, eligibility-undetermined, active, and negative cases.

110.4.3 Corrective Action Planning

Based on the data and program analysis, States must determine what corrective actions are to be implemented. States must address each error type however it remains the States decision which corrective actions they take to decrease or eliminate errors. It may not be cost effective to implement corrective actions for each and every error; States must determine what corrective actions to implement. States are encouraged to use the most cost effective corrective actions that can be implemented, to best correct and address the root causes of the errors. A cost benefit analysis will aid the State in calculating the total expected cost of corrective actions against the benefits of corrective actions. If the State determines that the cost of implementing a corrective action outweighs the benefits then the final decision of implementing the corrective action is the State's decision. The cost benefit analysis and the final decision should be documented in the State's Corrective Action Plans submitted to CMS.

Actions can be short or long term actions. Benefits for implementing corrective actions are reduction of improper payments and a management tool to promote efficiency in your program operations.

States should explain their overall approach towards CAP planning, identify their PERM error-rate target goal, as specified by CMS, and explain actions that the State is taking to meet this target goal. States should describe the corrective action initiatives that the State will implement and how these actions will reduce or eliminate improper payments, including:

- Specific error causes being targeted
- Timeline—listing expected due-dates for resolving the problem(s) (causes of errors)
- Describes the plan to monitor implementation of the corrective action plan
- Specify the name and title of the person who has overall responsibility for the CAP

States are required to address all errors including deficiencies, eligibility- undetermined, active, and negative cases. Beginning with the FY 2013 cycle, States are required to include corrective actions for eligibility technical errors.

110.4.4 Implementation and Monitoring

Develop an implementation schedule for each corrective action initiative whether it is Statewide or just in certain geographical areas. The implementation schedule must identify major tasks, key personnel or components responsible for each activity, and a timeline for each action including target implementation dates, milestones (e.g., start dates, final implementation dates), and the monitoring process. Federal regulations also specify that States must monitor their CAPs. The purpose of monitoring is to determine whether the implemented CAP is in the process of yielding intended results and meeting identified goals for reducing errors. Monitoring activities are ongoing, operational activities that the State undertakes while CAP activities are being implemented. Monitoring activities enable a State to keep track of its organization's ongoing efforts to reduce its PERM errors. An integral part of a successful corrective action program monitoring is maintaining a systematic approach for tracking and reporting the status of the corrective actions to successful closure and implementation.

States should develop an implementation schedule (timeline) for performing corrective action and describe the tasks necessary for CAP implementation and ties those tasks to the implementation schedule specifying milestones and implementation dates. States should describe their CAP evaluation activities and describe actions that the State takes to monitor implementation of its CAP.

110.4.5 Evaluation

Evaluate the effectiveness of the corrective action by assessing improvements in operations and/or error reduction. States may then decide to discontinue, modify, or terminate and replace the corrective action. States must evaluate the current corrective actions to be implemented by assessing all of the following:

- Improvements in operations
- Efficiencies
- Number of errors
- Improper payments

As part of its new CAP, States must evaluate and include updates on the previous corrective actions taken in their prior cycle including:

- Effectiveness of implemented corrective actions using reliable data; such as performing special studies, State audits, focus reviews, etc.
- When the action was implemented
- A status of the corrective action (is it complete, in progress, or ongoing?)
- Expected completion date and if the corrective action is on target
- Actions not implemented, and those actions, if any, that were substituted, ineffective, or abandoned actions and what actions were used as replacements
- Findings on short-term corrective actions
- The status of the long-term corrective actions
- States should determine if they meet PERM error-rate targets as identified by CMS

States should utilize the Medicaid FFS, managed care, and eligibility comparisons information in their cycle summary report to evaluate the effectiveness of the corrective actions taken in the previous cycle.

110.5 Corrective Action Plan Submission Details

CAPs are due to the assigned PERM State Liaison 90 calendar days after the date on which the State's error rates are posted on the RC's website. Once the error rates are published States will receive an official error rate notification, Medicaid and CHIP cycle summary reports, and a pre-populated State-specific CAP template for both Medicaid and CHIP. States are required to complete every section and address every error. The CAP template is based on information that went into the official State error rate, so this will include errors that were overturned during continued processing. In these cases States should note the overturn in the template and provide corrective actions to avoid continued processing in future cycles. States are not permitted to delete any portion of the CAP template. CMS encourages States to submit drafts to their designated PERM State Liaison prior to the due date to receive feedback prior to the final CAP submission date. While drafts are not required, they are strongly encouraged. Once the drafts are submitted, CMS will review them and provide additional feedback that States can incorporate into their final CAP submission. Final CAPs are submitted by the State to the appropriate PERM State Liaison for review and distribution to the appropriate CMS RO PERM contact staff. CMS will initially perform a high level review of the CAP to determine if each required element is addressed per regulation. If the CAP includes the required elements, the State will receive a letter of receipt acknowledging their CAP submission upon receipt of their CAP. If the CAP is not complete, States will receive a letter notifying them of the missing element(s) and request to submit a revised CAP. When all elements are complete, the State will receive the acknowledgment letter. CAPs will then undergo a detailed review by CMS, Regional Offices, CMS's contractors, and Medicaid Integrity Group. CMS will provide collaborative comments to the State and the State may or may not be asked to submit a revised CAP based on feedback. After review of the CAPs by all parties, an individual call may be held for further discussion if there are additional questions or concerns.

The CAP template instructions can be found on the PERM Website under the Corrective Action Tab.

110.6 Post CAP Submission Activities

- **March 15 through end of April** - After all CAPs have been evaluated, members of the PERM team, the PERM State Liaison, CMS RO PERM contact, if needed, will participate in a conference call with each State to discuss the findings, request clarification, and determine if additional information should be requested from the State.
- **Webinars and Onsite** – Each State is required to have a post-CAP webinar or onsite visit. This is an opportunity for active dialogue between the State, CMS, Regional Offices, and CMS’ contractors. CMS presents information to the State on PERM initiatives and proposed improvements to the next PERM measurement. The State is required to do an oral presentation of their CAP.
- **CAP** - Based on the meeting, States may need to submit revisions to their CAPs. States have 30 days from the meeting to submit revisions. States must notify their CAP liaison of any major changes to their corrective actions such as implementation, modifications, terminations, etc.
- **Follow-up** – The CMS CAP liaison will contact States on an annual basis to follow up on the State’s CAP implementation between cycles.

120. Recoveries

CMS expects to recover the federal share on a claim-by-claim basis from the overpayments found in error. Within the PERM process, the only funds that can be recovered are from claims that were actually sampled and found to have contained improper payments resulting in overpayments.

Recoveries of overpayments are governed by longstanding statutory and regulatory requirements. The statutory and regulatory requirements for Medicaid are found under section 1903(d)(2) of the Social Security Act, 42 CFR Part 433 subpart F and for CHIP under section 2105(c)(6)(B) and 2105(e) of the Social Security Act, 42 CFR Part 457 subpart B and F.

According to 42 CFR 431.1002, States must return to CMS the federal share of identified overpayments based on the PERM data processing and medical reviews. Payments based on erroneous Medicaid eligibility determinations are addressed under section 1903(u) of the Social Security Act and related regulations at 42 CFR Part 431, subpart P.

For purposes of PERM, States are considered to be officially notified by CMS of identified improper payments by 1) the posting of Medicaid and CHIP Final Errors for Recovery Reports on the designated CMS RC’s website and 2) by receiving an official letter with “notification of an overpayment” via email.

The posting of Monthly Final Errors For Recovery (FEFR) reports occurs on the first business day of each month (once medical and data processing reviews commence). The website postings

contain the errors that have gone through the difference resolution and CMS appeals process, as applicable, where the error findings were upheld as overpayments. All MR1 (no documentation) and MR2 (incomplete documentation) errors will be excluded from the monthly FEFR reports until the end of the cycle. This will allow States to continue to obtain these records from providers to reverse these errors if satisfactory documentation is obtained. At the end of the cycle, a comprehensive End of Cycle FEFR report will be generated which will include all final overpayment errors and the remaining MR1 and MR2 errors. These postings will be separately identified from claims posted for initial difference resolution. States can track recoveries of the federal share on an individual claim basis.

120.1 Monthly Final Errors for Recovery (FEFR) Report

Monthly FEFR reports are generated throughout a PERM cycle and include overpayments on claims that have undergone both a data processing and medical review and after all difference resolution/appeals timeframes have expired (in other words, errors show up on FEFR reports when they are final and have no chance to be overturned). Monthly FEFR reports are posted on the RC's State Medicaid Error Rate Findings (SMERF) website on the first business day of the month and are considered the State's official notification of an overpayment. Please note that since CMS accepts provider documentation until the cycle cutoff, no documentation or insufficient documentation errors (MR1 and MR2) are final until the end of the cycle. Therefore, MR1 and MR2 errors are not included on Monthly FEFR reports until the last FEFR report is created after the cycle cut-off date. State Medicaid and CHIP Directors are sent the official notifications via emails. The PERM State lead/contacts and CMS Regional Office financial contacts are also copied on these emails.

120.2 End of Cycle Final Errors for Recovery (FEFR) Report

The End of the Cycle FEFR report is posted to the SMERF website for a State after continued processing is completed and once all findings are final for the State for that cycle. The End of Cycle FEFR reports serves as the final list of overpayments for which a State must return the federal share for a PERM cycle. The report includes the total computable amount for the cycle. State' Medicaid and CHIP Directors are also sent the official notifications via emails.

120.3 RC's website

The Patient Protection and Affordable Care Act (the Affordable Care Act), section 6506, states that effective March 23, 2010 States have up to one year from the date of discovery of an overpayment for Medicaid and CHIP to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment.

120.3.1 Exceptions

There are some exceptions to the requirement to return the federal share of an overpayment within one year of identification:

- **A collection is received from the provider** – If the State receives recovery of the overpayment from the provider, the one year rule no longer applies. When the State receives the collection, the State must return the federal share on the next quarter ending CMS-64 and/or CMS-21 expenditure report.

- **The claim was adjusted to the correct amount** - PERM reviews claims paid or denied in each quarter of the federal fiscal year and includes adjustments made to the claims within 60 days of the original paid date. Thus, overpayments could be identified for claims that were later adjusted to the correct paid amount outside of the 60 day window. In such instances, the State is not required to return the federal share. The State should notify the PERM Recovery Lead and to provide documentation (e.g. screen shots, etc.) of the adjustment.
- **Provider successfully appeals to the State** – If a provider successfully appeals the error to an Administrative Law Judge (ALJ) the State can submit proof of the ALJ decision to the PERM recoveries lead and will not need to return the federal share of the overpayment. Many States have an informal appeals process in place that is preferable and less time consuming than a formal ALJ appeal. If an error is overturned through an informal appeals process the State should submit documentation to the PERM recoveries lead and CMS will review the documentation to determine whether or not the federal share needs to be returned.
- **Provider submits documentation after the cycle has ended** – After the cycle is over, when States send out recovery demand letters to providers, providers sometimes submit the outstanding medical record to the State (mostly for MR1 and MR2 non-response errors). Since this occurs after the cycle cutoff date, the claim will still be an error for PERM but CMS cannot in good faith request States to return the federal share if there is sufficient documentation to support the claim was paid correctly. The State should send the documentation to the PERM recovery lead through a password protected and encrypted CD. As a reminder, please do not send PII nor PHI information through the email. CMS’ PERM appeals panel will review the documentation and evaluate whether or not the claim was correctly paid based on the new documentation.

120.3.2 Underpayments

Underpayments are not included on PERM FEFR reports and are not a part of the PERM recoveries process. Typically, CMS is entitled to the Federal credit for overpayments whether the State has collected from the provider or not. However, CMS would not credit an underpayment until such time as the underpayment was actually corrected and paid at which point it would be reported as a normal operating expense and not an adjustment on an overpayments schedule.

Version Control Updates

Date	Version	Description of Changes and Updates	Author
July 12, 2013	1.0	Added version control table, updated where appropriate to 2012 language, added DP, MRR, MR updates to August 30, 2012 CMS PERM Manual	A+ PERM Team (LCH, CM, MB, SK, AK)
October 15, 2013	1.1	Made updates to Introduction (Section 10) and Claims and Sampling (Section 20), Eligibility Universe and Sampling (Section 30), Eligibility Reviews (Section 80), Error Code Table (Section 100), incorporated CMS edits, updated where appropriate to 2014 language	Lewin (JM, AH)
January 27, 2015	1.2	Made updates to the RC sections of the manual	A+ PERM Team (LCH, MB, SK)
August 2015	1.3	Overall updates to content and formatting, including removal of eligibility reflective of FY14-17 pilots	A+, Lewin, CMS