CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Payment Error Rate Measurement (PERM)

Introduction to PERM

September 2016

Centers for Medicare & Medicaid Services

Agenda

- History and Overview
- Methodology Overview
- Roles and Responsibilities
- Differences Between FY 2014 and FY 2017 Cycles
- FY 2017 Process Details
- Best Practices
- Communication and Collaboration
- Contact Information

History and Overview

Legal Basis for Measuring Medicaid and CHIP Improper Payments

- Improper Payments Information Act of 2002 (IPIA)
  - Medicaid and CHIP were identified as programs susceptible to improper payments
- Amended by
  - Improper Payments Elimination and Recovery Act of 2010 (IPERA)
    - Reaffirmed necessity of improper payment measurement and required additional “supplemental” measures
  - Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)
    - Emphasizes the importance of not only measuring improper payments but recovering and reducing improper payments

History of the Payment Error Rate Measurement (PERM) for Medicaid and CHIP

- Prior to FY 2001, there was no systematic means to measure improper payments in Medicaid or CHIP at the national level
  - Some states routinely measured payment accuracy but did not use a methodology that allowed national improper payment rate calculation
- From FY 2002 – FY 2004, CMS sponsored the voluntary Payment Accuracy Measurement (PAM) pilot
  - Tested and refined methodologies to measure payment accuracy rate in Fee-For-Service (FFS), managed care, and eligibility
- In FY 2006, CMS implemented the PERM methodology to estimate improper payments in Medicaid FFS
  - Began a 17-state rotation for PERM, where each state is reviewed once every three years
  - Began reporting a national improper payment rate for Medicaid for each federal Fiscal Year (FY)
- In FY 2007, CMS expanded the methodology to measure the accuracy of Medicaid managed care payments, CHIP FFS and managed care payments, and Medicaid and CHIP eligibility decisions

Continuing Evolution of the PERM Program

- In 2009, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - Required changes to the PERM methodology
  - Postponed CHIP measurement until new rules could be issued
- In 2010, CMS published a new PERM Final Rule in response to CHIPRA
  - State-specific sample sizes are calculated based on the prior year's component-level improper payment rates
  - Maximum sample sizes are set at 1,000 claims or cases for each component
  - States can substitute PERM for MEQC or vice versa
  - States are required to submit and implement corrective action plans that include: data and program analysis; corrective actions to be implemented; a plan for monitoring and evaluating implementation of corrective actions; and an evaluation of the previous cycle's corrective action plans
- During FY 2014, states were required to make significant changes to their Medicaid and CHIP programs in response to the implementation of the Affordable Care Act
  - PERM will continue to evolve alongside state Medicaid and CHIP programs and payments
- The FY 2014 – FY 2017 PERM cycles do not include an eligibility component review; during these years states will be participating in Medicaid and CHIP eligibility review pilots

PERM Methodology Overview

Measuring Payment Errors in Medicaid and CHIP

- The goal of PERM is to measure and report an unbiased estimate of the true improper payment rate for Medicaid and CHIP
- Because it is not feasible to verify the accuracy of every Medicaid and CHIP payment, CMS uses a statistically valid methodology that samples a small subset of payments, then extrapolates to the "universe" of payments

Sampling Overview

- PERM uses a two-stage sampling approach
  - CMS uses a 17-state rotation (each state is reviewed once every three years)
  - From within each state, select a stratified random sample of payments
  - Review the sampled payments for errors
  - Use the findings to estimate a national improper payment rate
- CMS calculates improper payment rates for the 17 states' Medicaid and CHIP programs each cycle and then combines with the improper payment rates for the states of the previous two cycles
  - The national-level rate includes the most recent rates for all states

PERM State Rotation

Cycle	Medicaid and CHIP States Measured by Cycle
Cycle 1 (FY15)	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2 (FY16)	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 3 (FY17)	**Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington**

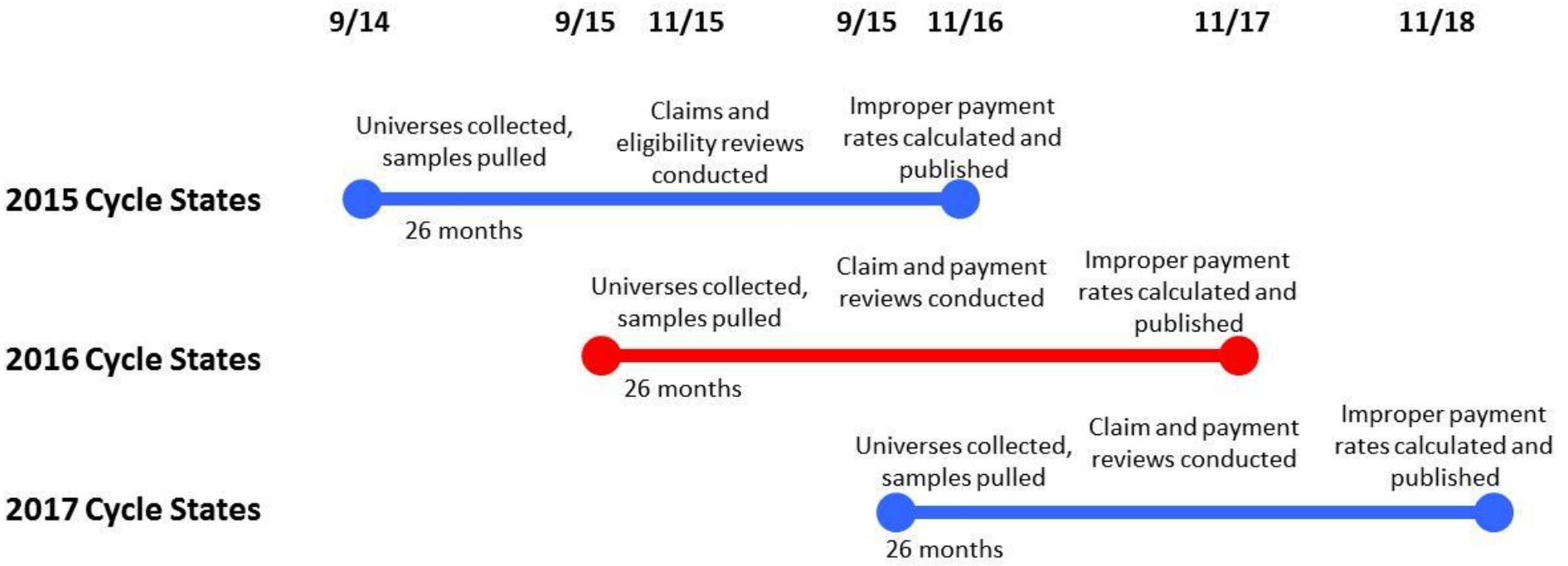
PERM Components and Sample Sizes

- PERM will review two components:
  - FFS
    - Sample consists of FFS claims and fixed payments
    - Medical review and data processing review
  - Managed care
    - Sample consists of capitated payments
    - Data processing review
- The FY 2017 PERM cycle will NOT include an eligibility component
- State-specific sample sizes are based on the prior year's improper payment rate and margin of error

PERM Cycle Progression

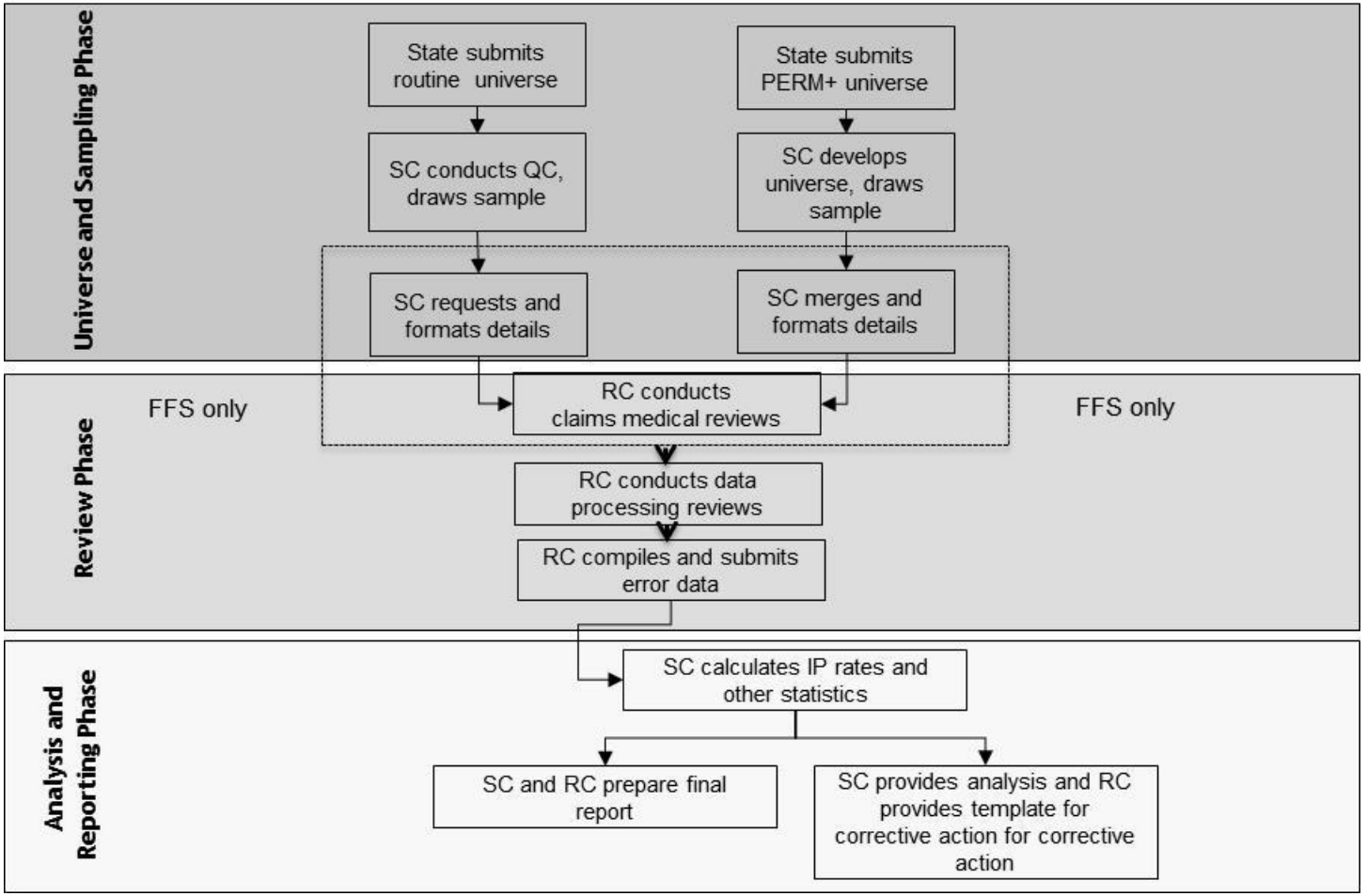
- Process of sampling and reviewing payments and calculating and reporting improper payment rates takes more than two years
  - Claims and payments for an entire fiscal year are collected
  - Payments are reviewed
  - Findings are used to calculate improper payment rates

PERM Cycle Progression



PERM Cycle Progression

Claims and Payment Measurement



Roles and Responsibilities

PERM Roles and Responsibilities

- Several organizations are involved in the PERM measurement
  - CMS
  - States
  - Statistical Contractor (SC)
  - Review Contractor (RC)

CMS PERM Team Responsibilities

- Structure the parameters for measurement through legal and policy decision-making processes
- Oversee the operation of PERM and PERM contractors to ensure that CMS meets its regulatory requirements
- Provide guidance and technical assistance to states throughout the process
- Ensure the measurement remains on track and work with states when challenges occur
- Host monthly cycle calls
- Review state-requested appeals of error findings
- Provide educational resources for Medicaid and CHIP providers
- Provide assistance as states develop corrective actions
- Ensure improper payments are recovered

State Responsibilities

- Provide a representative to spearhead PERM
- Educate state staff and vendors for MMIS or other data sources on the PERM process and data requirements
- Notify CMS and contractors in advance of any program changes, including new or ended programs, new reimbursement methodologies, or new systems
- Review claims and payment data submission instructions and attend intake meetings
- Provide claims and payment data to the SC
- Conduct a quality control review of claims and payment data prior to submission of the quarterly universes to ensure completeness of data and compliance with PERM specifications

State Responsibilities

- Provide timely and thorough responses to questions on the state-submitted data to support the PERM timeline
- Educate providers on the PERM process and assist with medical record collection
- Assist the RC with accessing state policies for review
- Assist the RC with on-site and/or remote data processing reviews
- Track errors and request Difference Resolutions (DRs)/appeals for differences and re-price partial errors
- Participate in monthly cycle calls with CMS
- Develop and implement corrective actions to reduce improper payments
- Return Federal Financial Participation (FFP) of FFS and managed care overpayments

Statistical Contractor Responsibilities

- Conduct Intake Meetings with each state
- Collect paid, zero dollar paid, and denied FFS and managed care universe data from states
- Perform quality control review on state submissions to ensure universes are accurate, compliant, and complete
  - Ensure all state submissions meet data requirements and request clarification or additional submissions as necessary
- Select stratified random samples, based on methodology shared with the states, from the universes on a quarterly basis

Statistical Contractor Responsibilities

- Request sample details from the states for sampled FFS claims for routine PERM states and build details for PERM+ states
- Deliver samples and details to the RC
- Provide assistance to the state and the RC to meet PERM timelines and promote efficiency
- Calculate the component (FFS and managed care), state, and national improper payment rates for Medicaid and CHIP
- Conduct analysis for corrective actions
- Assist in preparing final reports

Review Contractor Responsibilities

- Facilitate state implementation by confirming readiness prior to on-site or remote reviews, providing IT support, and overall reducing state burden
- Research, collect, and request Medicaid and CHIP state policies, including relevant state regulations, program information, fee schedules, systems, and billing manuals (March 2017 – April 2017)
- Conduct RC Educational Webinars for all states on data processing, medical record requests, and medical review processes (March 2017 – April 2017)
- Request medical records from providers (May 2017 – May 2018)
- Conduct data processing (DP) reviews on all sampled payments (July 2017 – June 2018)
- Conduct medical/coding reviews (MR) on relevant sampled FFS payments (August 2017 – June 2018)

Review Contractor Responsibilities

- Maintain the State Medicaid Error Rate Finding (SMERF) system, conduct SMERF training webinars, and provide state portals to track activities and findings
- Report final review findings to states through Sampling Unit Disposition (SUD) reports on the 15th and 30th of each month
- Review and respond to requests for difference resolution (DR)
- Process appeal requests for CMS review
- Notify states of final overpayment errors for recovery purposes on the first of each month after data processing and medical review has been completed for each claim
- Compile and submit final findings to the SC (August 2018 – September 2018)
- Assist in preparing final reports (September 2018 – November 2018)

Differences Between FY 2014 and FY 2017 Cycles

Difference between cycles (FY 14 & FY 17)

FY 2014 Cycle	FY 2017 Cycle
ICD-9 code sets used to report medical diagnoses and inpatient procedures	Replaced with ICD-10 code sets on October 1, 2015
FFS Stratification by 4 service types and "other" category	Back to previously used 10 payment strata (with the addition of a fixed payment strata) and zero/denied stratum
	The SC will be sending out timelines and issue logs to keep states informed about when samples and details will be completed and how issues have been resolved
Prior Cycle's DP review requirements	Added elements to the DP review: • Verify compliance with ICD-10 codes • Verify the state compliance with FCBC requirements for high risk providers • Verify state compliance with provider revalidation requirements
States emailed RC lead reviewer pending DP documentation	States will submit all documentation to RC's central office in Rockville, Maryland (by SFTP, secure email, or mail)
Only 1 DP error and 1 MR error could be identified on a sampled claim	All DP errors and MR errors can be cited on a sampled claim, so states know about all issues and can take action

Difference between cycles (FY 14 & FY 17)

FY 2014 Cycle	FY 2017 Cycle
P1 reports for pending DP claims not dynamic	• P1 reports now dynamic and updated real time and weekly SMERF notices for tracking pending DP claims • P1 conversion to DP 13 errors, late documentation can be submitted until cycle cut off
	Changes to MR and DP error codes and qualifiers: • Additional MR and DP error codes • Expanded qualifiers for greater specificity
PERM Review Contractor specific record request letters	Medical record request letters are now standard to match all of CMS request letters sent to providers
No Review Contractor SFTP required	Two SFTP accounts will be established for each state to facilitate submission of PHI to RC and to access all letters sent to providers, and access medical records for errors cited for DR consideration

Difference between cycles (FY 14 & FY 17)

FY 2014 Cycle	FY 2017 Cycle
No DP Checklist	States complete DP check list in preparation for DP reviews
No Review Contractor Cycle Manager	RC cycle manager to facilitate cycle implementation for states
Individual state orientation calls	RC is hosting combined educational webinars with states, and RC will have individual check in calls with each state throughout the cycle, as needed

SMERF 2.0	Enhanced SMERF system:
	• More user friendly
	• Increased functionality
	  • Added CAP analysis tab
	  • Ability to create individualized reports
	  • CAP addendum report
	  • CAP Interactive Module for online development of CAPs, revisions, CMS acknowledgement letters and approvals.

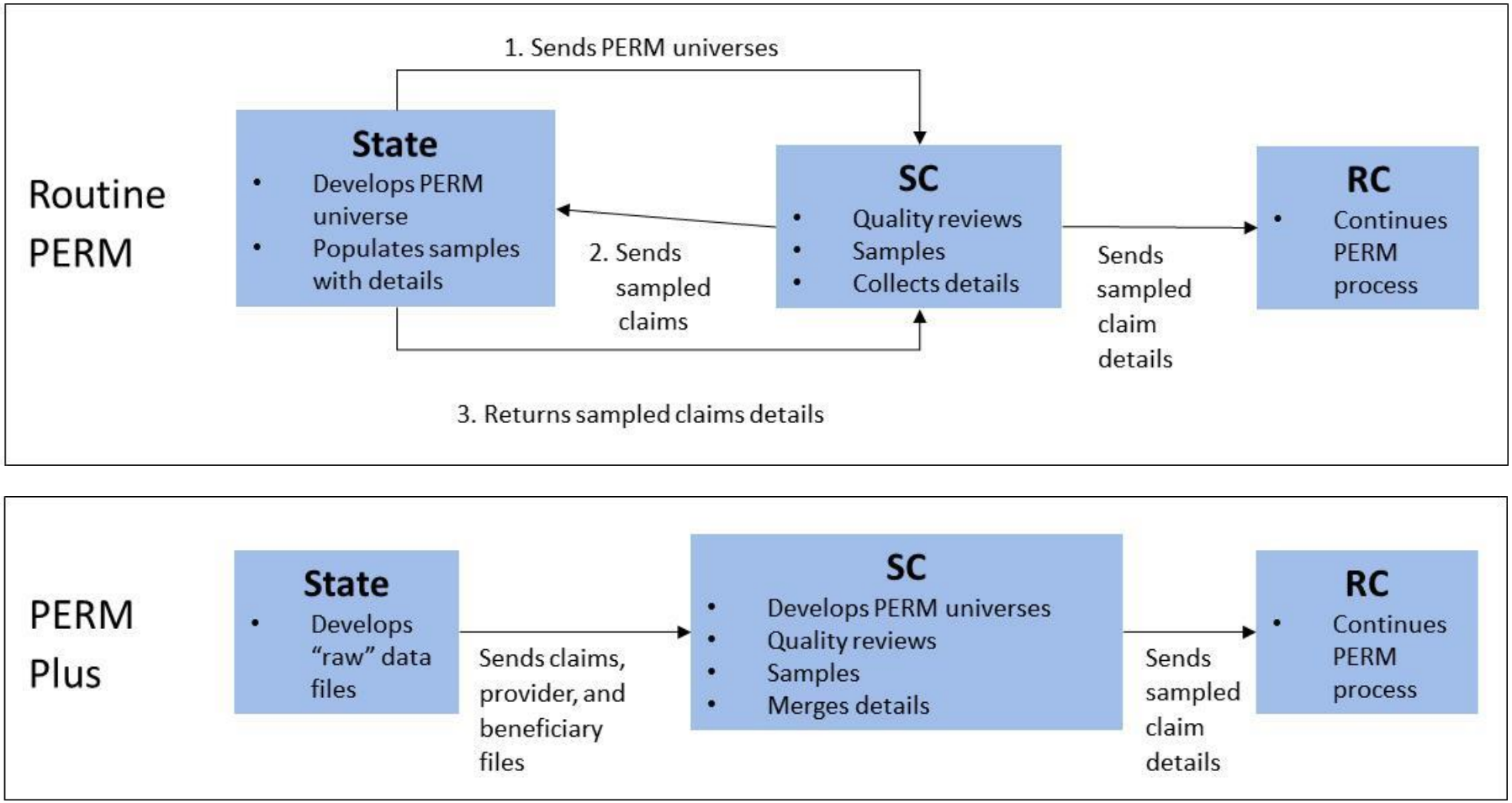
DP Reviews average 2-4 weeks	• DP reviews average 3-8 weeks due to increased sample sizes and increased review requirements

Differences Between FY 2014 and FY 2017 PERM Cycles

- New fields required in PERM data submission
  - ICD Indicator: Indicates which ICD coding set is applicable to the claim line
  - Units Billed: Used to indicate Units of Service billed if that number is different from the value in the Units Paid field
  - Routine PERM only: Beneficiary name (only required for “fixed” payments)
- The ICD Indicator and Units Billed fields are submitted in the PERM+ universe submission or in the routine PERM details submission

Process Details

Statistical Contractor: Universe Collection and Sampling



Statistical Contractor: Universe Collection

- PERM independently samples payments from four universes or program areas
  - Medicaid FFS
  - CHIP FFS
  - Medicaid managed care
  - CHIP managed care
- The PERM universe contains most Medicaid and CHIP service payments that are fully adjudicated by the state that are matched by federal funds each quarter
  - Includes individual claims, capitation payments, and payments processed outside of MMIS or made in aggregate for multiple services
  - Excludes claim adjustments, administrative payments, state-only expenditures, and certain payments as defined in regulation
- Certain fields (e.g. date paid, amount paid) have PERM-specific definitions that are important for consistency

Statistical Contractor: Sampling

- Both FFS and managed care universes are stratified prior to sampling; FY2017 will follow the stratification below
  - FFS is stratified into 10 dollar-weighted strata with two additional strata: one for fixed payments, Medicare premiums, and Medicare crossovers and one for denied/zero paid claims
  - Managed care is stratified into 10 dollar-weighted strata
- The Statistical Contractor will calculate state-specific sample sizes for each claim component in each state (final sample sizes sent to states on 8/31)

Statistical Contractor: Improper Payment Rate Calculation

- For each state, improper payment rates are estimated separately for Medicaid and CHIP
  - Improper payment rates are estimated using a sample of claims
- FFS and managed care rates are calculated separately (where applicable)
- The FFS and managed care rates are combined to make the claims rate using the state expenditures in each program as weights
- The claims rate is then combined with the eligibility rate
  - Note that for FY 2017, no state-specific eligibility improper payment rates will be calculated due to the suspension of the PERM eligibility measurement

Review Contractor: Collection of State Policies

- Send initial email to states prior to implementation
  - Explain policy collection process and timeframes
  - Establish policy contacts with each state
- Download policies from state websites (as much as possible)
- Policies accessible in SMERF system
- Complete policy questionnaires and Master Policy Lists (MPLs) and submit to states for review
- Check for policy updates throughout the cycle
- Written approval of MPLs needed from states before medical review can begin

Review Contractor: Data Processing Reviews

- RC Educational Webinars are held with all states in the cycle before starting DP reviews
- DP reviews are conducted on each sampled FFS claim, fixed payment, and managed care payment
- The RC validates that the claim was processed correctly based on information found in the state's claims processing system and provider files
- Reviews can take place on-site at the state or remotely
- Data Processing orientation is scheduled with each state prior to reviews
  - Review state system(s) questionnaires completed by states
  - Review any special programs (waivers, etc.)
  - Demonstrate any new systems
  - Determine and gather desk aids, manuals, and website links needed for training DP reviewers
  - Discuss remote vs. on-site reviews and establish tentative dates to begin reviews
- **New**States track pending DP reviews through SMERF and receive automated notices for overdue pending information needed to complete reviews

Review Contractor: Data Processing Reviews

DP Review Elements - Recipient

- Recipient ID
- Date of Death
- Date of Birth/Age
- County of Residence
- Gender
- Citizenship Status
- Living Arrangements
- Aid category and benefit plan
- Managed Care Enrollment Rules and History
- Patient Liability (share of costs), if applicable
- Medicare and/or other insurance coverage (TPL)
- Eligibility Source System Verification

Review Contractor: Data Processing Reviews

Verification of Provider Enrollment

(only applicable when provider is required to be enrolled)

- Name
- NPI Number
- Active Enrollment
- Active License (if required)
- Active CLIA (if required)
- Type/specialty
- Service Location

- Sanctions
- Suspension Periods
- OIG Exclusion List
- Risk-based screening of newly enrolled providers
- ****New**** provider revalidation – claims paid after 3/24/16 (unless provider was notified prior to 3/24/16; then must be screened by 9/24/16)
- ****New**** Fingerprinting and criminal background checks for high risk providers for claims paid after 6/1/2016 or effective date of a CMS approved compliance plan

Review Contractor: Data Processing Reviews

Verification of Accurate Payment

- Determine whether claim was filed timely
- Determine compliance with HIPAA 5010 transaction standards for electronic claims
- ****New**** Determine if system uses ICD10 codes for claims with Date of Service on or after 10/1/2015
- Was claim for a covered service?
- Was claim priced accurately based on the Fee Schedule in effect for the Date of Service?
- Determine if claim is a duplicate of a previously paid claim
- Identify, report and consider any adjustments to the sampled payment made within 60 days of original payment

Review Contractor: Data Processing Reviews

Miscellaneous Payment Information

- Prior Authorizations (PAs) required under the state's policies
- View and compare scanned images of hard copy claims and attachments with system information
- Payments for "Sister Agencies" that receive pass-through Federal Financial Participation (FFP)

Review Contractor: Data Processing Reviews

Managed Care Capitation Payment

- Recipient information
- Health Plan information
- Capitation Rates per Health Plan
- Geographic Service areas (county, zip code, etc.)
- Rate Cells
- Exclusions/Carve Outs
- Capitation Payment history screens
- Partial month coverage/ recoupment policy
- Roll-Out dates (if staged implementation was in effect)
- Duplicate payment/ adjustment check

Review Contractor: Medical Record Requests

- RC educational webinars are held with all states to review Medical Record Request processes before starting to call providers
- Use provider information from details data files submitted by states
- Initial call to provider to verify provider information
  - State support needed for incorrect/non-current contact information
- Initial request packet sent to provider
  - CMS letter (with authority to request records)
  - PERM fax cover sheet with specific documentation request list for each claim category sampled
  - Claim summary data provided for specific claim sampled
  - Instructions for record submission methods

Review Contractor: Medical Record Requests

- Providers have 75 calendar days to send in medical records
  - The RC will follow-up with reminder calls and letters at 30 days, 45 days, and 60 days, if not received
  - A 75 day non-response letter (MR1 error) is sent to providers and made available to states through their SFTP accounts
- Incomplete documentation: Providers have 14 calendar days to send in documentation in response to additional documentation requests
  - Specific detail provided verbally and in writing for missing documentation – reminder calls and letters at 7 days
  - A 15 day non-response letter (MR2 error) is sent to providers and made available to states through their SFTP accounts
- Late documentation can be accepted until the cycle cut off date

Review Contractor: Medical Reviews

- Medical Review orientations are held for all cycle states, as part of the RC Educational Webinars, to include
  - Medical review process
  - Difference Resolution/Appeals process
  - Medical review/policy questionnaire
- Conducted only on sampled FFS claims
- Utilizes claims data submitted by states, records submitted by providers, and collected state policies
- Validates whether the claim was paid correctly by assessing the following
  - Adherence to states' guidelines and policies related to the service type
  - Completeness of medical record documentation to substantiate the claim
  - Medical necessity of the service provided
  - Validation that the service was provided as ordered and billed
  - Claim was correctly coded

Review Contractor: State Medicaid Error Rate Finding (SMERF) System

- Tracks all sampled unit workload, receipt of medical records, reviews completed, and final results
- Provides real-time information on status of record requests and receipts; progress of reviews for both DP and medical reviews
- State's access includes ability to create and/or download reports, file for Difference Resolution and CMS appeals, and access Final Error For Recovery Reports for recovery of overpayment errors
- Training and access to the SMERF system is provided for states (April – May 2017) before records are requested or reviews are started
- Access is limited to states, contractors, and CMS through password protection

Best Practices

Best Practices for States: Working with the Statistical Contractor

- Assign a dedicated contact person (data manager) for all communications
- Include all relevant staff in the intake meetings
  - For general intake meetings it is important that all departments that will be pulling data or responding to questions about PERM data be in attendance
  - If vendors will be pulling and/or submitting PERM data, they should be included in intake meetings and calls with the SC
  - All relevant financial staff should be included in the CMS 64/21 intake meetings
- Check FTP compatibility before submitting the Q1 data
  - This includes encrypting, password-protecting, and uploading file
- Submit test data to ensure that the submission can be read and reviewed by the Statistical Contractor
  - For PERM+ states, this means sending provider and claims files so that merge issues can be identified

Best Practices for States: Working with the Statistical Contractor

- Keep a list of all data sources and ensure that data from all sources are included in the state's transmission each quarter
- Include subject matter experts as part of the PERM team early in the cycle to gain clear understanding of data submission instructions and PERM requirements
- Refer to information from the previous cycle, as appropriate, to resolve issues and answer questions
- Participate in regular meetings with the SC to resolve data issues if there are significant complications or delays
- Perform a round of CMS-64/21 reconciliation early in the cycle to ensure that corrections in data submission can be made for the remaining quarters
- For PERM+ states, work with the Statistical Contractor to identify the most efficient method of submitting data, which may include submitting some data through a routine PERM method

Best Practices for States: Working with the Review Contractor

- Allocate resources to PERM throughout the cycle at each phase of the project (policy collection, provider record requests, data processing review, and medical review)
- Correct any issues identified from the last PERM measurement cycle
- Collaborate with the Review Contractor to explain the state's programs, data, and policies
- If the state routinely purges claims
  - Have the purge process held until after PERM reviews
  - If already purged prior to sampling, identify all purged sampled claims and have the full claim re-populated in the system prior to the start of DP reviews

Best Practices for States: Working with the Review Contractor

- Keep provider licensing information updated in the MMIS system
- Update provider contacts in MMIS for claims sampled for PERM before the state submits quarterly detail data to the Statistical Contractor
- Send outreach letters to each sampled provider about the PERM program and MRR processes before MRRs begin
- Provide the RC with updated provider contact information, as needed
- Identify a contact person for corporate medical organizations, school systems, and state fiscal agencies

Best Practices for States: Working with the Review Contractor

- Develop integrity teams to assist with locating and contacting providers, when needed
- Track all medical record requests in SMERF to assure providers' timely responses
- Contact providers on all non-response error letters (MR1s for no documentation and MR2s for incomplete documentation) to submit requested documentation
- Review all errors cited and determine if a DR request should be filed within 20 business days of the SUD report
- All errors that should be partial errors must have a DR request to re-price the claim and submit written evidence

Communication and Collaboration

Communication and Collaboration

- **FY 2017 PERM Cycle 3 Calls**
  - The cycle calls will occur on the Fourth Tuesday of each month from 3:00 – 4:00 pm Eastern Time
  - First cycle call will be held on Tuesday, October 25, 2016

- **PERM Technical Advisory Group (TAG)**
  - Quarterly TAG calls as a forum to discuss PERM policy issues and recommendations to improve the program
  - Regional TAG reps

- **CMS PERM Website**
  - www.cms.gov/PERM

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