



# Payment Error Rate Measurement (PERM)



**Introduction to PERM  
October 2013**

*Centers for Medicare &  
Medicaid Services*

# Agenda

- History and Overview
- Methodology
- Roles and Responsibilities
- Differences Between FY 2011 and FY 2014 Cycles
- FY 2014 Process Details
- Best Practices
- Communication and Collaboration
- Contact Information

# History and Overview

# Legal Basis for Measuring Medicaid and CHIP Improper Payments

- In 2002, Congress enacted the Improper Payments Information Act of 2002 (IPIA)
  - ❑ Medicaid and CHIP were identified as programs susceptible to improper payments
- IPIA was amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA)
  - ❑ Reaffirmed necessity of improper payment measurement and required additional “supplemental” measures
- IPERA was amended by the 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 error rate calculation
- From FY 2002 – FY 2004, CMS sponsored the voluntary Payment Accuracy Measurement (PAM) pilot
  - ❑ Tested and refined methodologies to measure payment accuracy rate in fee-for-service (FFS), managed care, and eligibility

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

- In FY 2006, CMS implemented the PERM methodology to estimate improper payments in FFS Medicaid
  - ❑ Began a 17-state rotation for PERM where each state is reviewed once every three years
  - ❑ Began reporting a national error rate for Medicaid for each federal fiscal year
- 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 error 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

# Continuing Evolution of the PERM Program

- In FY 2014, states will be 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 updates and changes to state Medicaid and CHIP programs and payment methodologies

# 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 error rate for Medicaid and CHIP
- Because it is impossible to verify the accuracy of every Medicaid and CHIP payment, CMS uses a statistically valid methodology that samples a small subset of payments and then extrapolates to the “universe” of payments

# Sampling Overview

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

# PERM State Rotation

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

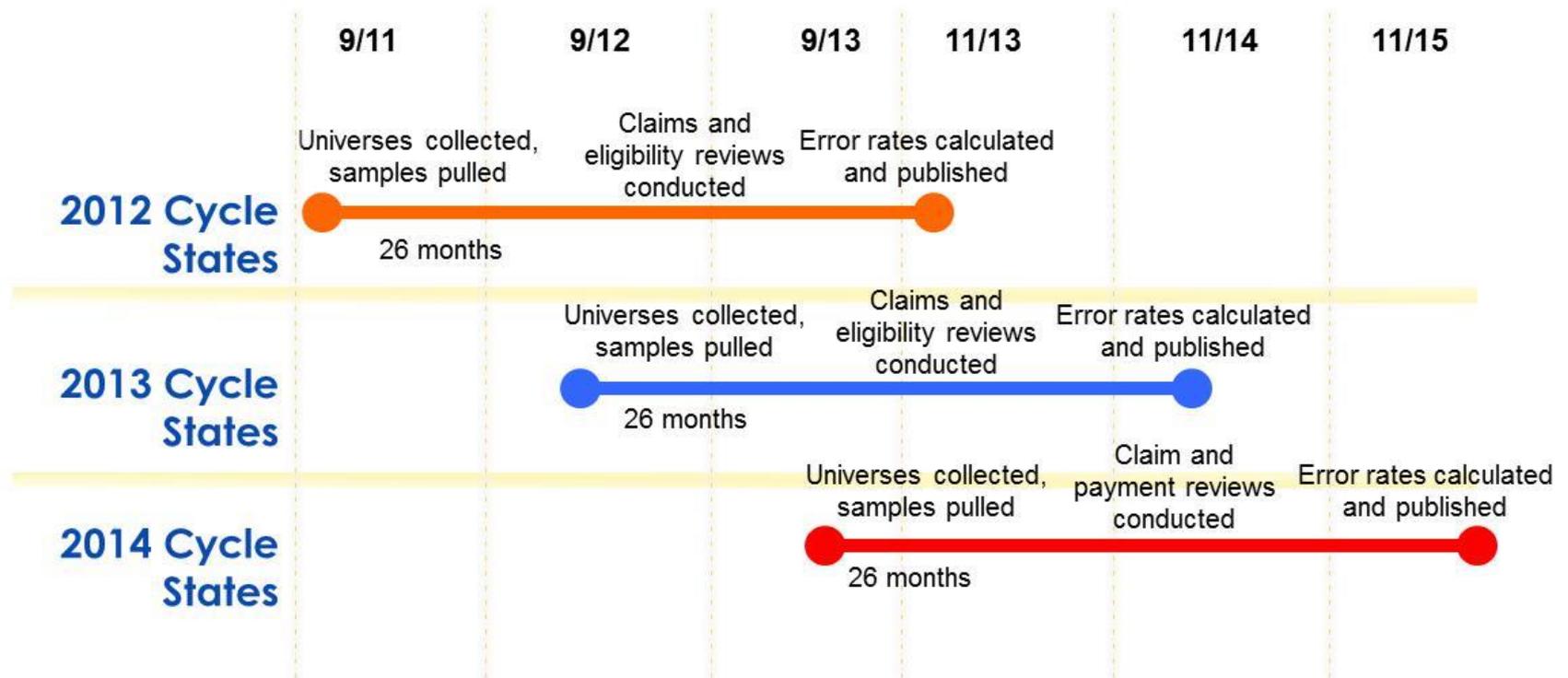
# PERM Components and Sample Sizes

- PERM will review two components:
  - FFS
    - Sample consists of FFS claims
    - Medical review and data processing review
  - Managed care
    - Sample consists of capitated payments
    - Data processing review
- The FY 2014 PERM cycle will NOT include an eligibility component
- State-specific sample sizes are based on the prior year's error rate and margin of error

# PERM Cycle Progression

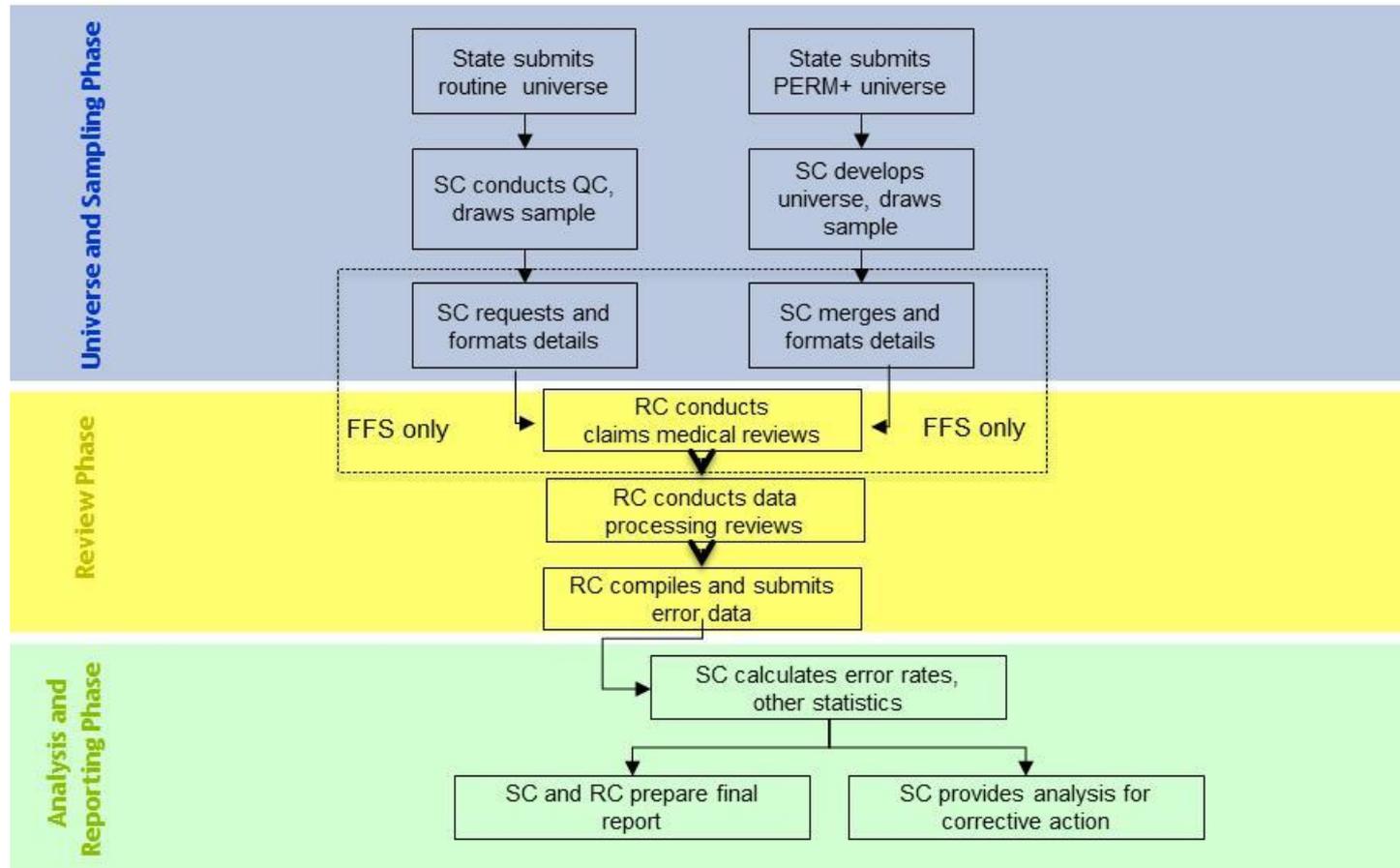
- Process of sampling and reviewing payments and calculating and reporting error rates takes more than two years
  - ❑ Claims and payments for an entire fiscal year are collected
  - ❑ Payments are reviewed
  - ❑ Findings are used to calculate error rates

# 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
  - ❑ Review Contractor

# CMS PERM Team Responsibilities

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

# CMS PERM Team Responsibilities

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

# State Responsibilities

- Provide a representative to spearhead PERM
- Provide claims and payment data to Statistical Contractor
- Educate providers on PERM process and assist with medical record collection
- Assist Review Contractor with accessing state policies for review
- Assist Review Contractor with on-site and/or remote data processing reviews

# State Responsibilities

- Request difference resolution/appeals for differences and re-price partial errors
- Participate in cycle calls with CMS
- Develop and implement corrective actions to reduce improper payments
- Return Federal Financial Participation (FFP) of fee-for-service and managed care overpayments

# Statistical Contractor Responsibilities

- Conduct intake meetings with each state
- Collect fee-for-service and managed care universe data from states
- Perform quality control review on state universe to ensure accurate and complete universes
- Select random samples from the universes on a quarterly basis
- Request details from the states for sampled fee-for-service claims in routine PERM states and build details for PERM+ states
- Deliver samples and details to Review Contractor

# Statistical Contractor Responsibilities

- Calculate the component (FFS, managed care), state, and national error rates for Medicaid and CHIP
- Conduct analysis for corrective action
- Assist in preparing final report

# Review Contractor Responsibilities

- Research, collect, and request Medicaid and CHIP state policies including program information, fee schedules, systems, and billing manuals
- Request medical records from providers
- Conduct data processing and medical record requests/ medical review orientations for each state
- Conduct data processing reviews on all sampled payments
- Conduct medical/coding reviews on relevant sampled FFS payments

# Review Contractor Responsibilities

- Maintain the SMERF 2.0 website with state portals to track activities and findings
- Report final review findings to states
- Review and respond to requests for difference resolution
- Process appeal requests for CMS review
- Notify states of final overpayment errors for recovery purposes
- Assist in preparing final report

# Differences Between FY2011 and FY2014 Cycles

# Differences Between FY 2011 and FY 2014 PERM Cycles

FY 2011	FY 2014
One submission timeline for FFS and managed care universe data	States can submit Q1 managed care data with Q2 universe submission
Stratification by dollar value for FFS sampling	Stratification by service type for FFS sampling
Same FFS and managed care sample sizes for all CHIP programs (unless state accepted FY 2008 CHIP error rate)	State-specific CHIP sample sizes for each component

# Differences Between FY 2011 and FY 2014 PERM Cycles

FY 2011	FY 2014
No provider-specific names or ID numbers required in fee-for-service routine PERM universe data	Submission of referring provider name and NPI required in all universe submissions (routine PERM and PERM+)
Fee-for-service claims details meetings with state held on an as-needed basis	Fee-for-service claims details meetings will be scheduled with all states
	Review Contractor will conduct medical record request intake meetings with each state prior to requesting records

# Differences Between FY 2011 and FY 2014 PERM Cycles

FY 2011	FY 2014
	Added elements to the DP review: <ul style="list-style-type: none"><li>- OIG LEIE verification</li><li>- Referring/ordering provider enrollment</li><li>- Risk-based screening of newly enrolled providers</li></ul>
Old SMERF website	New SMERF 2.0
Open Forum PERM Provider Education Calls	Interactive PERM Provider Education Webinars

# Differences Between FY 2011 and FY 2014 PERM Cycles

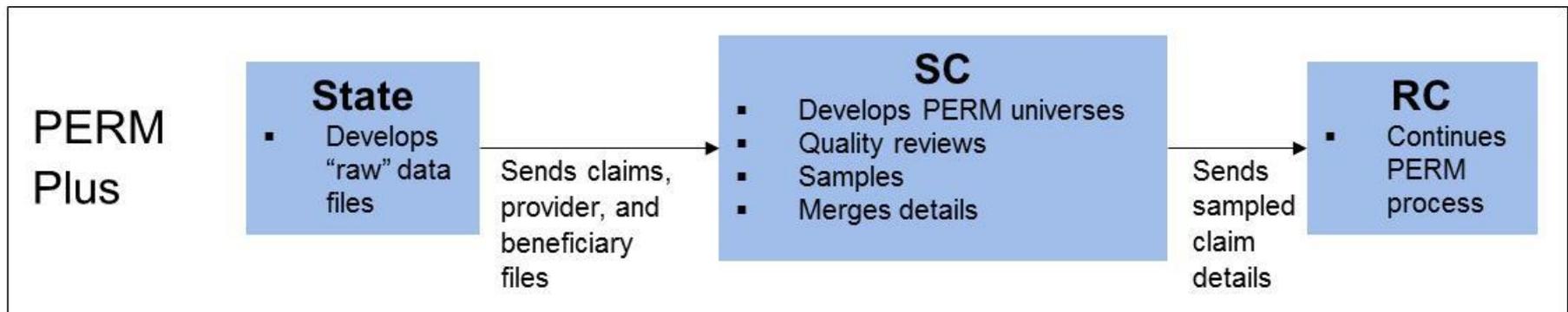
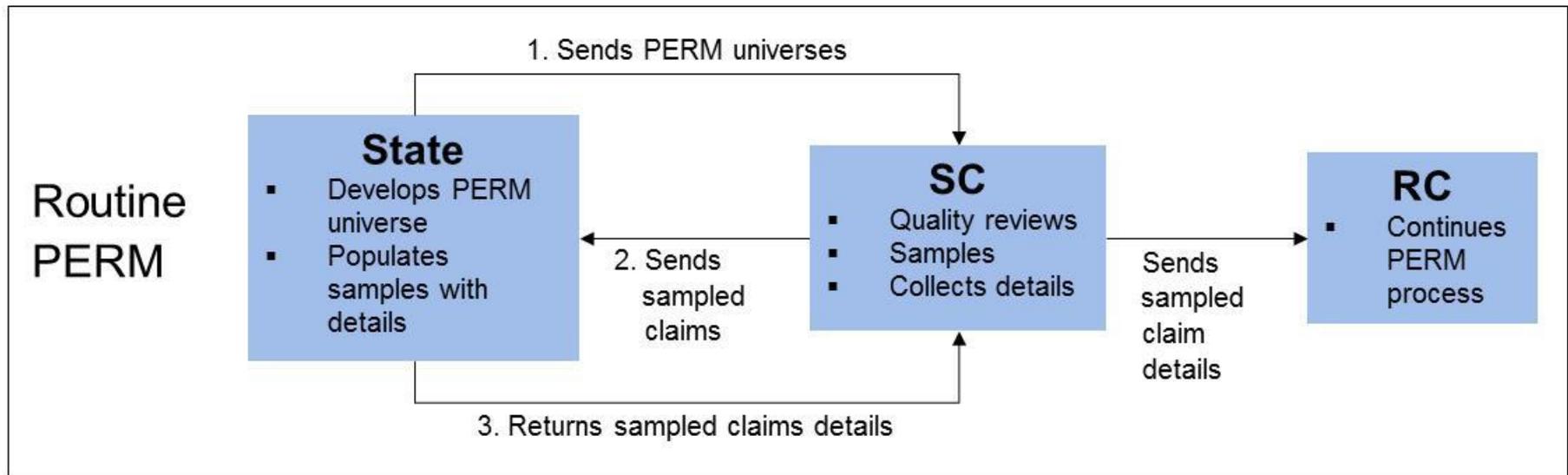
FY 2011	FY 2014
<p>PERM reviewed three components: FFS, managed care, and eligibility. States conducted PERM eligibility reviews. State-specific eligibility error rates issued.</p>	<p>PERM will only review FFS and managed care. No state-specific eligibility error rates.</p>

# Differences Between FY 2011 and FY 2014 PERM Cycles

- New fields required in routine PERM data submission:
  - ❑ Service date from/through (only required for “fixed” payments)
  - ❑ Billing provider name
  - ❑ Billing provider legacy/state ID
  - ❑ Billing provider NPI
  - ❑ Performing provider name
  - ❑ Performing provider legacy/state ID
  - ❑ Performing provider NPI
  - ❑ Referring provider name
  - ❑ Referring provider legacy/state ID (\*also required for PERM+)
  - ❑ Referring provider NPI (\*also required for PERM+)
  - ❑ Beneficiary ID (only required for “fixed” payments)

# 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

# Statistical Contractor: Universe Collection

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

# Statistical Contractor: Sampling

- In FY 2014, each program area is divided into strata based on service type
- The Statistical Contractor will calculate state-specific sample sizes for each claims component for each state
  - FFS
  - Managed care

# Statistical Contractor: Error Rate Calculation

- For each state, error rates are estimated for Medicaid and CHIP
  - Payment error rates, based on a sample of claims
    - If a state has both FFS and managed care, separate payment error rates are estimated, then weighted together according to expenditures
- For each program (Medicaid and CHIP) a combined error rate is estimated that combines the FFS and managed care payment rates with the eligibility rate for the program
  - Note that for FY 2014, no state-specific eligibility error rates will be calculated due to the suspension of the PERM eligibility measurement through FY 2016

# Review Contractor: Collection of State Policies

- Send initial email and letter
  - ❑ Explain policy collection process and timeframes
  - ❑ Establish policy contacts with each state
- Download policies from state websites (as much as possible)
- Policy abstraction and storage to policy acquisition and management module
- Complete policy questionnaire
- Request to schedule medical record requests/medical review orientation call
  - ❑ Review PERM medical review process
  - ❑ Review policy questionnaire and identify outstanding policies needed during MR orientation call
  - ❑ Confirmation by state of Master Policy List (MPL)
  - ❑ Review medical record request process and timeframes
  - ❑ Review medical record request questionnaire
- Check for policy updates
- Written approval of MPL needed from states before medical review can begin

# Review Contractor: Medical Record Requests

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

# Review Contractor: Medical Record Requests

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

# Review Contractor: DP Review

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

# Review Contractor: DP Review

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

# Review Contractor: Medical/Coding Reviews

- Medical review required for FFS claims only (excludes denials, Medicare Part A and B premium payments, primary care case management payments)
- Basic components include:
  - ❑ Review sampled units from RC website
  - ❑ Electronic access to collected and stored policies and records
  - ❑ Determine sufficiency of documentation submitted

# Review Contractor: Medical/Coding Reviews

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

# Review Contractor: RC Website

- Tracks all sampled unit workload, receipt of medical records, reviews 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 RC website provided for states during the month when reviews begin
- Access limited to states, contractors, and CMS through password protection

# Best Practices

# Best Practices—Statistical Contractor

- Check FTP compatibility before submitting the Q1 data
  - This includes encrypting, password-protecting, and uploading file
- Keep a list of all data sources and ensure that data from all sources 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
- Raise questions with the Statistical Contractor if data does not clearly match the PERM instructions

# Best Practices—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 last PERM measurement cycle
- If state routinely purges claims:
  - ❑ Have the purge process held until after PERM reviews; or
  - ❑ If already purged prior to sampling, identify all purged sampled claims and have full claim re-populated in system prior to start of DP reviews

# Best Practices—Review Contractor

- Keep provider licensing information updated in MMIS system
- Update provider contacts in MMIS for claims sampled for PERM before state submits quarterly detail data to the Statistical Contractor
- 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 insufficient documentation) to submit requested documentation

# Communication and Collaboration

# Communication and Collaboration

- Cycle calls
  - ❑ Scheduled for the first Tuesday of every month 3:00-4:00 PM EDT
- CMS PERM website
  - <http://www.cms.gov/PERM>
- Technical Advisory Group (TAG)
  - ❑ Quarterly TAG calls as a forum to discuss PERM policy issues and recommendations to improve the program
  - ❑ Regional TAG Reps

# CMS Contact Information

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