

**Payment Error Rate Measurement (PERM)  
Corrective Action Summary**

A. State: XXXXXXXX

Fiscal Year: 2012

B. Date: 2/19/2013

C. State Contact: XXXXXXXXXXXX  
Phone Number: 999-888-2222  
Email Address: stateemployee@dhs.state.XX.us

D. Medicaid Error Rate: 0.00%  
Fee-for-service rate: 0.00%  
Managed care rate: 0.00%  
Eligibility payment rate: 0.00%

E. CHIP Error Rate: 0.0%  
Fee-for-service rate: 0.0%  
Managed care rate: 0.00%  
Eligibility payment rate: 0.0%

F. Summary of Major Error Causes and Applicable Corrective Actions

**Medicaid**

**Fee-for-service:**

**Major Error Causes:** No documentation. Insufficient documentation. Procedure coding error. FFS claim for a managed care service.

**Corrective Actions:** Provider education on recordkeeping requirements. Provider education on billing accuracy with length of procedure and severity of condition. Employee education.

**Managed Care:**

**Major Error Causes:** Non-covered services

**Corrective Actions:** A date of death field will be included on the Hospital Report (New Born Child or Children) Form (FNNNA).

**Eligibility:**

**Major Error Causes:** Ineligible cases due to excess resources, residency, household composition, excess earned income, unearned income, and nursing facility residency.

- **Corrective Actions:** Conduct increased trainings on proper policy and procedures, including the need to verify and request information. Conduct Quality Control reviews on error-prone elements. Create an e-mail address for supervisors to identify and submit training needs on a monthly basis; training needs will also be identified through Supervisory Review System (SRS) findings. Continue with Corrective Action Panel.

**Payment Error Rate Measurement (PERM)  
Detailed Corrective Action Plan**

A. **State:** XXXXXXXX

**Fiscal Year:** 2012

B. **State Contact:** XXXXXXXX  
**Phone Number:** 999-888-2222  
**Email Address:** stateemployee@dhs.state.XX.us

C. **Program:** Medicaid

D. **Component:** Fee-for-Service

E. **Narrative**

1. **Data Analysis:** (clusters of errors, causes, characteristics, and nature of each error)

**Error Element:** Fourteen (14) instances of MR 1 - Failure to provide medical records.

**Nature:** These errors resulted in a total overpayment identified of \$15,428.02, and accounted for 50% of the total errors identified during the medical records review and 31.78% of the dollar amount. The two most costly errors by far concerned two different facilities serving clients with mental retardation and developmental disabilities. One facility was an ICF/MR, with a \$6,570 error, and the other was a community residential care facility with a \$6,384.90 error. Together these two errors accounted for about 84% of the dollar value of the MR1 errors. Other MR1 errors were attributed to pharmacies, clinics, and other practitioners.

**Error Element:** Six (6) instances of MR2 errors – Insufficient documentation.

**Nature:** Insufficient documentation was the cause of 25% of the total medical review errors and 20% of the total dollars in error. The overpayment identified for these errors totaled \$9,637.85. Once again, a community residential care facility for clients with developmental disabilities was the cause of the error with the highest dollar value - \$6,217.05. A hospital in-patient claim was the next largest error at \$3,208.88. These two claims alone accounted for 97.8% of all Medicaid MR2 errors. In addition, one other MR2 error had zero dollars associated with the error.

2. **Program Analysis:** Describe the results of the program analysis including specific programmatic causes and root causes to which the errors were attributed.

**Programmatic Causes:** Provider did not submit medical records, lack of awareness by providers of importance of medical records; insufficient communication with providers; failure to document medical necessity; coding errors by providers.

Root Causes of Errors:

**(1) MR1 – Failure to Provide the Medical record:** The provider that provided the services – normally the servicing provider in MMIS - was not always the “keeper” of the medical record. Conversely, the contact in MMIS may have been a corporate address or State Agency business office, but the actual medical records were kept in the field office. Another possible scenario was that the records request was sent to a personal care aide (the direct provider of services) but the medical records were kept by a case manager. For example, the two biggest MR1 errors involved providers of residential care for clients with mental retardation and development disability. A third MR1 error involved a local agency responsible for case management services to the MR/RD population. While the servicing providers received the request for Medical records, the state agency charged with oversight of services to this population, as well as with paying these providers, was totally unaware of the requests for records. The state agency wasn’t aware of the PERM errors and subsequent repayment liability until it received the final error letter from DHHS (even though bulletins about PERM had been sent to all providers.) In other MR1 errors, especially those involving chain retail pharmacies, the medical records request went to a corporate location when the records actually resided with the local pharmacy. A third type of provider – diagnostic/lab – also may not have kept the type of medical records needed for PERM, as this is an out-of-state lab.

It is also possible that the type of providers committing MR1 errors had never been involved in a PERM-type sample before. For example, no MR1 errors for the Medicaid population involved hospital claims. Hospital providers are more accustomed to sending records for utilization review and understand the concept of a “technical denial.”

**(2) MR2 – Insufficient Documentation:** DHHS did intervene and contacted providers personally in an effort to obtain the additional records requested. The costliest error was due to a facility for clients with developmental disabilities failing to send in the correct documentation.

3. **Corrective Actions:** Identify the corrective actions planned for major error causes. For each corrective action planned, describe the expected results.

**The corrective actions planned to address the error causes:**

**Enhancing Provider Communication and Education**

- DHHS will address PERM errors through the Provider Newsletter. DHHS Division of Program Integrity has provided information about Medicaid fraud and abuse for the newsletter, as well as information on common coding errors made by providers. The intent is to prevent mis-billing through provider education. The next issues of the provider newsletter will discuss the errors

made by providers that contributed to the error rate, and let them know as PERM comes again to our State in 20XX, their compliance is needed.

- In addition to notifying providers through newsletters and bulletins, DHHS will contact all state agency providers who are selected for PERM in 20XX in order to verify the contact person and the location of the medical records. We will also obtain the correct mailing address for the PERM medical records request letters and send this information to the contractor prior to the beginning of the reviews.
- DHHS is currently revising its contract for a QIO. This contract will have a much stronger provider education component in the scope of work. This can be used as a vehicle to address errors such as failing to send in the medical records and failing to meet the criteria for medical necessity. Under the QIO utilization review process, "technical denial" is a common finding, and occurs when the provider fails to send in the medical record for review. This is very similar to the PERM MR1 finding. Therefore, the provider education component of the QIO contract can impact PERM errors as well.

#### **Provider Sanctions / Reviews:**

- After DHHS was notified of final PERM errors by CMS, each provider with a Medicaid medical records error was sent a letter by the DHHS PERM coordinator, under the agency director's signature, explaining the error and informing them that repayment of the claim would occur. The PERM coordinator then set up an accounts receivable for each PERM error and the providers in question were invoiced by the DHHS accounting division. After 90 days, any provider who failed to meet their repayment obligation would be sent a second letter warning them of other sanctions, such as suspension from the Medicaid program, if they failed to repay the claims found in error by PERM.
- Subsequent PI reviews will be used to reinforce findings as a result of PERM. This does not necessarily mean that PI reviews were opened just because a provider had an error in the claim, although several PI reviews were opened on providers with PERM errors albeit for other reasons. However, PERM can provide a good tool for Program Integrity reviewers to use when explaining to providers why failing to keep accurate records is a compliance issue, and could be a fraud and abuse issue.
- DHHS recently obtained a vendor to provide additional support to Program Integrity for overpayment identification and recovery. This vendor will extend PI reviews to areas, such as inpatient hospital, where previously DHHS lacked sufficient audit resources. This vendor will help Program Integrity focus on other provider types, such as pharmacy, physicians, and home health, which also are at risk for PERM errors. It is expected that the contractor will look for the same type of payment errors as PERM through desk reviews, data mining and medical record reviews.

4. **Implementation and Monitoring:** Provide an implementation schedule for each corrective action. Provide a timeline including target dates, milestones and monitoring.
- Target Dates:  
Summer 20XX for Provider Newsletter  
Provider PERM Error Letters: August 20XX to Present  
Overpayment Identification and Recovery Contract – April 1, 20XX kick-off date
  - Monitoring:  
On-going Program Integrity Reviews  
Monthly QIO reviews  
On-going data mining by Program Integrity
  - Milestones: Reduction in errors resulting from PERM medical records review as well as technical denial rates by the QIO.
5. **Evaluation:** Evaluate the effectiveness of the corrective action by assessing improvements in operations and/or less incidence of errors.
- **Expected Results:** Educating and sensitizing providers to the PERM review process as well as added staffing hours to communicate and track requests for provider documentation is expected to result in 1) increased compliance in provision of required medical record documentation; 2) saving both the agency and provider time and resources on unnecessary appeals where documentation was not submitted timely, but the provider later produces on appeal to avoid penalty; and 3) likely reduction of overall claims error rate by 50% or an error rate less than 5%.

A. **State:** XXXXXXXX

**Fiscal Year:** 2012

B. **State Contact:** XXXXXXXX

**Phone Number:** 999-888-2222

**Email Address:** stateemployee@dhs.state.XX.us

C. **Program:** Medicaid

D. **Component:** Medicaid Managed Care

E. **Narrative**

1. **Data Analysis:**

**Error Element:** One (1) instance of DP2 error- non-covered service.

**Nature:** One (1) premium payment for a managed care provider was found to be in error during the PERM data processing reviews (DP) which accounts for 100% of the total dollars in error. The client was not eligible for continuous Medicaid resulting in a \$1,034.26 overpayment. The Health and Human Services Commission's (HHSC) Office of Eligibility Services New Born Data Integrity Unit processed this case with continuous eligibility yet the client's birth and death occurred on the same date.

2. **Program Analysis:** Describe the results of the program analysis including specific programmatic causes and root causes to which errors were attributed.

**Programmatic Causes: Medicaid Managed Care**

- DP2- Non-covered service: The Department of State Health Services manual Form F-NNNN which is used by hospitals for reporting the birth of a child to the HHSC Office of Eligibility Services for does not have a field for reporting date of death. Eligibility staff certified the child with continuous eligibility although it should have been opened and closed.

**Root Cause of Errors: Medicaid Managed Care**

- DP2- non-covered service: The form FNNNN does not capture date of death. In addition, this error was identified by the state prior to the PERM data processing review. The premium was adjusted timely and the federal share refunded. However, the correction was not made within the 60 day period for adjustments in accordance with PERM review rules.

3. **Corrective Actions:** Identify the corrective actions planned for major error causes. For each corrective action planned, describe the expected results.

- DP2-non-covered services Managed Care: A date of death field will be included on the Hospital Report (New Born Child or Children) Form (FNNNA). In addition, internal discussion will occur to identify other ways to capture the date of death of a newborn thus reducing non-covered service errors.

**4. Implementation and Monitoring:** Provide an implementation schedule for each corrective action. Provide a timeline including target dates, milestones and monitoring.

- a. August 2010- DP2- Non-covered service: The Hospital Report (New Born Child or Children) Form (FNNNA) form has been updated to include the date of death.

**5. Evaluation:** Evaluate the effectiveness of the corrective action by assessing improvements in operations and/or less incidence of errors.

BBSC will monitor and evaluated the effectiveness of the correction action by reviewing the reduction in specific errors resulting from PERM medical records and data processing reviews and other internal quality assurance methods, internal, external audits and management reviews.

Example CAR

A. State: xxxxxxxxxxxx

B. State Contact: xxxxxxxxxxxx

Telephone Number: 999-888-2222

E-Mail Address: stateemployee@dhs.state.XX.us

C. Medicaid

D. Eligibility

E. Narrative:

### 1. Data Analysis

#### Medicaid Not Eligible and Managed Care

The eligibility and managed care errors were due to: four excess liquid resources, one household composition; one improperly enrolled, and two Other State Criteria. Eight Medicaid cases were determined to be Not Eligible or Improperly Enrolled.

Error Element: Four instances of excess resources.

Nature:

- Over the \$2000 resource limit for SSI-related nursing facility. Review filed 4/10 listed two bank accounts. QC verified as of 3/31/10 balances were \$483.98 and \$4,375.67 for a total of \$5,007.10. [QC Review PF0060 11/10, Co3/SA2]
- Over the \$5000 resource limit for adults on FMAP. RRED filed 5/27/10 declared \$52,000 CD, bank accounts of \$4000 and \$200 cash. Equipment was listed with a value of \$97,581.00. In addition the household had several vehicles and a life insurance policy. QC obtained verification. [QC Review PF0062 11/10, Co33/SA2]
- Over the \$2000 resource limit for SSI-related medical Elderly Waiver program. 2/11 Review included verification of \$8041.15 liquid resources. Notice of 6/30/11 approved medical effective 6/1/11 for elderly waiver at which time liquid resources totaled \$7460.15 per verification obtained by QC. [QC Review PF0476 9/11, Co23/SA3]
- Client was over the \$2000 resource limit for the Elderly Waiver program. Bank accounts of \$6871.03 were reported on the 6/11 Review form and bank statements provided by the household showed a balance of \$6,129.31. MCE1 – Spend down was calculated. [QC Review PF0468 9/11, Co 57/SA4]

Error Element: Household composition.

Nature:

- Client was given FMAP eligibility when there were no eligible children in the FMAP household. The only child was in Newborn status. [QC Review PF0246 3/11, Co77/SA5]

Error Element: Other State Criteria

Nature:

- Client is required to sign a Care premium agreement. Client filed the Health and Financial Support application and did not sign the separate Care premium agreement. [QC Review PF0191 2/11, Co77/SA5]
- Care Renewal application signature page was not received. [QC Review PF0483 9/11, Co82/SA3]

Error Element: MCE2, Eligible for Managed Care, but improperly enrolled

Nature: Client had in-kind income calculated with a Presumed Maximum Value of \$244.66. Based on this income, client should have been approved for 14-3 Eligible for SSI-A, Receives No Cash Benefits instead of Medically Needy. Per policy, a person is not eligible for Medically Needy if the person is eligible for another coverage group. [QC Review PF0142, 1/11, Co10/SA2]

**Medicaid Undetermined Cases**

Two reviews were undetermined as there was not enough information in the case record to make a conclusion for the review month and QC was unable to contact the client.

Error Element: Undetermined

Nature:

- PF0322 (5/11, Co57/SA4) was an Iowa Care case on which there were questions of whether the adults were married and the amount of self employment income. The Reviewer tried, but was unable to contact the client by telephone or by mail to resolve these questions.
- PD0340 (6/11, Co77/SA5) was a MAC case that the LO office processed without verifying the father's earnings for the review month of 11/2010. QC checked WAGEA but the self-declared earnings were higher than the actual 3<sup>rd</sup> quarter earnings and lower than the 4<sup>th</sup> quarter earnings.

**Medicaid Liability Errors**

There were 14 Medicaid reviews with liability errors. The majority of the liability errors six related to calculating client participation using the actual monthly interest income. Three liability errors were on household composition, two were on lump sum income, and there were three other single occurrence errors.

Error Element: Client Participation

Nature:

- The client participation was calculated by multiplying the per diem nursing home benefit by 30 rather than 30.4. (PF0212 3/11 136, Co78/SA1)

- Earned income and interest was projected rather than using the actual amount to determine client participation (PF0237, 3/11, 632, Co78/SA1)
- Client participation was understated due to not considering interest (\$0.53). Poverty level was entered incorrectly. (PF0218, 3/11 136, Co 78/SA1)
- Client participation was understated due to not considering interest (\$0.18). Poverty level was entered incorrectly. (PF0228, 3/11, 136, Co78/SA1)
- Client participation was understated due to not considering interest income (\$0.02). Poverty level was entered incorrectly. (PF0230, 3/11 136, Co78/SA1)
- Client participation was understated due to not considering interest income (\$0.07). Poverty level was entered incorrectly. (PF0270, 4/11 136, Co64/SA2)
- Client participation was understated due to not considering interest income (\$0.08). Poverty level was entered incorrectly. (PF0331, 5/11 136, Co31/SA3)
- Client participation was understated due to not considering interest (\$0.10). (PF0229, 3/11, 136, Co78/SA1)

Error Element: Household Composition

Nature:

- LO used two person household; should have included two children making it a four person household. (PF0045, 11/10, 60E C077/SA5)
- LO did not count an older child living in home even though she was listed as dependent on income taxes. Boyfriend should not be counted in the household size for IowaCare although he is the father of a child in the home. (PF0179, 2/11, 60E Co64/SA2)
- An automatic redetermination was done for child because she turned 1 year old and newborn status ended. Husband was in the home and not counted as a household member. (PF0347, 6/11 MAC Co77/SA5)

Error Element: Lump Sum Income

Nature:

- The local office worker counted the entire IPERS disbursement as a resource and calculated ongoing medically needy with \$0 spend down. Employer's share of lump sum should have been considered unearned income for the MN certification period. (PF0456, 8/11 37E C064/SA2)
- LA approved client for FMAP effective 12/2010 when the household had received a countable (recurring gifts) lump sum. The lump sum should have been prorated based on test 2 for the household size. The case should have been a MN case with a spend down. (PF0311 5/11 FMAP, C0 82/SA 3).

Error Element: Transitional Medical Timeframes

Nature:

- LA approved transitional medicaid for an additional six months when the household had already used the 12 month. After 6 months eligibility was extended for an additional 12. (PF0046 11/10 370, Co82/SA3)

**Medicaid Negative Errors:**

There were 156 Negative Title19 cases sampled with thirteen incorrect actions [8.3%]. One case was an Improper Denial and twelve were Improper Terminations. The categories with the highest percentage of errors were in the MAC and FMAP category with nine of the thirteen negative action errors (69.2% of all errors); and one case each for IowaCare, FIP [Family Investment Program], Transitional Medicaid, and MEPD [30.8% of all errors].

Error Element: Improper Denial

Nature:

- Phone interview was missed. IM Worker denied application. The children on the application should not be denied because of a missed interview. (PFN0105, 6/11,308, Co50/SA4)

Error Element: Improper Termination

Nature:

- The closure was the result of the administrative actions that were needed for the rest of the household members on whose case the newborn child's eligibility was also carried. (PFN0045,1/11,920,Co34/SA2)
- A Transitional Medical case should not have been terminated until the end of the sixth month of TM coverage. (PFN114,6/11,370,Co7/SA2)
- Child was taken off case when there was DIA non-cooperation. (PFN123,7/11,308,Co33/SA2), (PFN0068,3/11,308,Co23/SA3)
- LO canceled MEPD coverage due to no earned income without first establishing whether the client intended to return to work within 6 months. (PFN155,9/11,60-M,Co77/SA5)
- There is not a copy of the DIA report in the file, it is unknown when the report was issued to the agency, when it was received by the local office, or the wording on the report. Therefore, QC determined this was an invalid negative because the case file is incomplete. (PFN142,8/11,308,Co97/SA1)
- IMW received an email from client stating has been exited from the FaDSS program and had moved out of state to Illinois. The IMW closed benefits for the household on 5/18/11 effective 6/1/11 because the household did not live in Iowa. However, the client called into the LO on 5/23/11 stating she did not move to Illinois as originally planned. (PFN0092,5/11,308,Co52/SA4)
- Cert period end dates were entered incorrectly; therefore IABC terminated. (PFN0017, 6/10,60E, Co94/SA2)
- No documentation in case of why terminated: Medicaid was canceled without notifying the HH of the effective date of closure or the reason for cancellation. (PFN0018,11/10,920,Co64/SA2)
- Review form filed 5/16/11. Med closed 5/23/11 with no notice reason. (000s entered). OLN states an RFI was sent, but it could not be found in the file. (PFN 0094,5/11,920, Co77/SA5)
- No Notice of Decision was found to support the action taken to cancel benefits. (PFN128,7/11,308,Co94/SA2)

- The cancellation occurred because the review coding was not entered by the monthly system cut-off date, which triggered the issuance of an automated cancellation notice. (PFN0041,1/11,300,Co23/SA3)

### **Medicaid Technical Errors**

The FFY2011 CMS PERM guidance defines case deficiencies that do not lead to an eligibility error, but indicate problems in case processing as technical errors. For FFY2011, the top four technical errors identified by DHS were:

- Other State Criteria
- Citizenship/Identity Documentation
- Wages and Salaries
- Combined Gross and Net

These deficiencies were cited as technical errors and were collected to provide the state with information to be used during the Corrective Action planning. If a case was noted as ineligible, no technical error was cited. Of the 504 active cases that were reviewed, Other State Criteria were cited for 48 (39%) of the technical errors; followed by Citizenship Documentation with 30 (25%) technical errors; Wages and Salaries with 15 (12%); and Combined Gross and Net with 9 (7%). They account for 80% [102 of the 127] of the total technical errors.

Error Elements: Wages and Salaries, Combined Gross & Net Income

Nature:

- PF 0504 – Divided three months wages by two instead of three to determine the average
- PF0440 – Worker did not verify date of last check so counted one check in the month instead of two
- PF0213 – Worker used net income instead of gross.

Error Elements: Other State Criteria

Nature:

- Failure to document Citizenship. Form 470-4381, Documentation of Citizenship and Identity, was required, but was missing from the file.
- Failure to complete HIPP referral when employment was reported. (Other State Criteria)
- PF0494 – No documentation of how income was determined.

## **2. Program Analysis**

Programmatic Causes: The majority of errors were because the Local Office failed to follow proper policy and procedures. Error trends are in the areas of liquid resources, household composition and using interest income to calculate client participation.

## **Root Causes of Medicaid Eligibility and Managed Care Errors:**

Error Element: Liquid resources.

Root Cause:

- PF0060 - IM Worker did not verify the value of the two bank accounts listed on the Review form. Due to size of caseloads, worker did not question whether the household exceeded resource limits.
- PF0062, PF0476, PH0468 Information showing that the value of liquid resources exceeded the program limit was in the file, but was not acted on by the the IM Worker, possibly due to the size of the caseloads.
- PF0476 – Bank statements were in the file, however, before the Elderly Waiver application was filed the client was determined eligible for a medicare savings program which had a higher resource limit. The change in coverage groups may have contributed to the cause of the error.
- PF0468 – Excess resources had been previously reported and verified, but were apparently overlooked when the worker processed the review. Client was eligible for Medically Needy with a spend down but not the elderly waiver program.

Error Element: Household composition.

Root Cause:

- PF0246 - The worker did not refer back to the Medicaid Employees' Manual when approving a parent for Family Medical Assistance when the only child was in newborn status. The parents should have been given the opportunity to remove the child from newborn status in order to determine FMAP eligibility for the parent.
- The other household member issues causing liability errors appear to have occurred due to an incomplete review of the case file at the time of processing.

Error Element: Client participation – Interest income.

Root Cause:

- Interest income must be averaged and projected for six months and then recalculated based on actual income to correctly determine the client participation amount. (PF0218, PF0228, PF0230, PF0270, PF0331, PF0229). In these cases, interest income was not used.
- PF0212 - LO should use the daily nursing home benefit times 30.4 to determine the average monthly insurance benefit instead of 30.0. This amount is to be added to the client participation. This error appears to have been the result of a misunderstanding of policy.

Error Element: Lump Sum Income

Root Cause:

- PF0456 - Per policy the employee's share of a lump-sum retirement payout is a resource upon receipt, but the portion paid by the employer is income. Consider a nonrecurring lump sum as unearned income in the the month received and count it in determining eligibility during the period of proration. The household was over the resource limit of \$2,000 for an applicant household, so the case was determined to be Medically Needy with a zero spend down. Use of the prorated lump sum income would have resulted in a higher spend down. This error appears to have been the result of a misunderstanding of policy.
- PF0311 - Lump sum should have been prorated over future months and a determination made of the Medically Needy spend down. This error appears to have been the result of a misunderstanding of policy.

Error Element: Other State Criteria

Root Cause:

- PF0483, PF0191 - Applications must be signed to be valid and Care cases, that the time of the action reviewed, were required to include a signed Premium Agreement. In these two cases it appears that the lack of signature documents was overlooked by the application worker.

**Root Causes of Medicaid Undetermined cases:**

Error: Element: Undetermined

Root Cause

- PF0322, PF0340 - Two cases had questionable information the reviewer was not able to resolve due to the failure of the client to respond to QC inquiries.
- Complete verification was missing from the case file.
- In one case there was an indication of changes that may have been missed at time of enrollment. Due to the inability of the reviewer to contact the household additional verification was not available.
- Since there is no sanction for households that do not cooperate with PERM reviews, Quality Control staff do not have that incentive to encourage cooperation.

**Root Causes of Medicaid Technical Errors:**

Numerous examples of failure to complete the required form to document how citizenship and identity were verified and failure complete referrals to the HIPP unit represented the majority of the technical errors. The trend regarding technical income errors was in failure to take the time to carefully consider the verification and determine the correct amount of income to use for the eligibility determination.

**Root Causes of Medicaid Negative Errors:**

Programmatic Causes: The majority of negative Medicaid errors were because Local Office failed to follow proper policy and procedures in denying or terminating Medicaid coverage. One trend was noticed in canceling or denying children for reasons that would have made the adults ineligible, but coverage should have continued for the children (4 reviews). Another trend was that cases were canceled without issuing a notice of decision (3 reviews).

Error Element: Continuously eligible children canceled

Root Cause:

- Cause appears to be overlooking the need to continue eligibility for the children.
- Another possible cause is taking action on another program at the same time, such as Food Assistance, which has different requirements regarding closing individuals or the entire case.
- Possibly the worker was not sure how to handle the case action on the system in one step.

Error Element: Cases canceled without a notice of decision

Root Cause:

- Case may have been canceled without a notice as a work management technique so the worker could process it later in the month without concerning the client who was cooperating in providing additional information.

### 3. Medicaid Corrective Actions

Type of Error	Cause	Strategy	Implementation
Resources – cases being certified when countable resources actually exceeded program limits. Programs: Nursing Facility (1), FMAP (1), Elderly Waiver (2)	Either overlooking the resources noted in the case file or misunderstanding policy on countable resources that does differ between coverage groups.	Refresher training will be conducted on countable resources limits for adults and when verification is required.  Policy on resources for family-related Medicaid is expected to be different under the ACA rules.	See below
Household Composition established	The policy on requiring a child who is not in	Provide refresher training on establishing proper	See below

incorrectly	<p>newborn status to be part of the eligible group in order to approve parents for family medical was misunderstood or not applied. Children were not included in household size when they should have been. The second adult in the home not treated appropriately for household size determination.</p>	<p>household composition and thoroughly reviewing the case file to identify household members who may have been missed.</p> <p>Policy on household composition for family-related Medicaid is expected to be different under the ACA rules.</p> <p>The new rules-based eligibility system may make these actions easier because relationships will be coded for each individual and will be clearly displayed.</p>	
Members were enrolled in Medically Needy with no spend down when they would have been eligible for another coverage group.	Misapplication of policy	The PERM Review lead to the discovery of a group of people in similar circumstances in one particular area of the state. Cases were all corrected after the review results were released.	Completed
Iowa Care applications filed on the multi-program application form were approved without having clients sign the Premium Agreement making the	The multi-program application does not have a Premium Agreement as part of the application and workers forgot to have the client sign the separate sheet.	Rules were changes in 2012 to require a premium agreement only when the client owes a premium. The change has significantly reduced the occurrence of this error.	Completed

case ineligible.			
Case was approved using an unsigned application.	Unsigned application was either overlooked or the signature page was provided but was not scanned into the Electronic Case Record.	Field staff will establish a procedure for handling applications in ECF with a missing signature page.	See below
Interest Income	Actual interest income was not correctly counted for client participation. Error may be caused solely by the PERM administrative period policies.	The policy on determining countable interest income for client participation was clarified in 2011. Nursing facility cases are now handled by a specialized/centralized unit whose staff are familiar with determining client participation.	Completed
Lump Sum Income	One error was on the lump sum receipt of retirement benefits and one error was on the proration of a recurring lump sum payment.	Policy is clear on this topic. The two errors do not represent a trend.	Not applicable
Children were canceled when the adults were canceled, but the children should have remained continuously eligible.	Policy misunderstood or not applied. System actions may not have been understood.	Provide refresher training on policy and system actions related to continuous eligibility for children.  New rules-based eligibility system currently in development should prevent denying an individual for the wrong reason.	See below
Some cases were closed	Cancelations were possibly	Field staff will establish a procedure	See below

without sending notification to the household.	used as a work management technique to allow for more processing time.	for processing renewals without closing cases with no notification.  The new rules-based eligibility system may prevent negative actions being processed with no notification.	
The form, 470-4381, Documentation of Citizenship and Identity was not in the file when required	The form may have been completed but not included in the back-scanning sent to Electronic Case File, or it may have been determined to be a low priority and not completed when required.	Policy is being changed so that this particular form will no longer be required.	By March 2013 via Memo from the System and Policy Response system (Help Desk)
Referrals to the Health Insurance Premium Payment unit were not done when required	Referrals may have been overlooked or appeared to have been unnecessary. Previous policy required a referral within two days of the report of any job.	Policy changed in 2012 to require a HIPP referral only when insurance is available from that particular employer. This has reduced the need to make referrals and has significantly reduced the occurrence of this error.	Completed

**Expected Results:** Iowa DHS expects a reduction or elimination of similar errors in the future with these corrective action strategies.

#### 4. Medicaid Implementation and Monitoring

Major Tasks/ Strategies	Target Dates	Milestones	Monitoring
Refresher training	<i>Completion by</i>	<i>July 1, 2013 –</i>	<i>Program Managers,</i>

will be conducted on countable resources limits for adults and when verification is required to improve accuracy.	<i>October 1, 2013</i>	<i>Training will be scheduled, if not completed. Follow-up at monthly IM Administrator meetings.</i>	<i>IM Training Academy, Corrective Action Coordinator</i>
Provide refresher training on establishing proper household composition and thoroughly reviewing the case file to identify household members who may have been missed to improve accuracy.	<i>Completion by October 1, 2013</i>	<i>July 1, 2013 – Training will be scheduled, if not completed. Follow-up at monthly IM Administrator meetings.</i>	<i>Program Managers, IM Training Academy, Corrective Action Coordinator</i>
Field staff will establish a procedure for handling applications in ECF with a missing signature page to improve accuracy.	<i>Completion by October 1, 2013</i>	<i>July 1, 2013 – Training will be scheduled, if not completed. Follow-up at monthly IM Administrator meetings.</i>	<i>Program Managers, IM Administrators, Corrective Action Coordinator</i>
Provide refresher training on policy and system actions related to continuous eligibility for children to improve accuracy.	<i>Completion by October 1, 2013</i>	<i>July 1, 2013 – Training will be scheduled, if not completed. Follow-up at monthly IM Administrator meetings.</i>	<i>Program Managers, IM Training Academy, Corrective Action Coordinator</i>
Field staff will establish a procedure for processing renewals without closing cases with no notification to improve accuracy.	<i>Completion by October 1, 2013</i>	<i>July 1, 2013 – Training will be scheduled, if not completed. Follow-up at monthly IM Administrator meetings.</i>	<i>Program Managers, IM Administrators, Corrective Action Coordinator</i>
Quality Control will continue internal	<i>Ongoing</i>	<i>Ongoing</i>	<i>Program Managers, IM Administrators,</i>

PERM reviews for Medicaid and CHIP until the next federal review cycle begins.			<i>Corrective Action Coordinator</i>
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**5. Evaluation:** Evaluation will consist of data analysis and assessment of the internal PERM reviews for Medicaid and CHIP that will continue until the next federal review cycle commences. Errors and error trends are presented and discussed at each monthly Income Maintenance Administrator meeting. Strategies will be evaluated based on reduction in similar errors. Modifications will be made to corrective action strategies, as appropriate, which may include improvements in operations and procedural efficiencies.

Example CAP

**Payment Error Rate Measurement (PERM)  
Detailed Corrective Action Plan**

**A. State:** XXXXXXXX **Fiscal Year:** 2012

**B. State Contact:** XXXXXXXX  
**Phone Number:** 999-888-2222  
**Email Address:** stateemployee@dhs.state.XX.us

**C. Program:** Medicaid

**D. Component:** Eligibility

**E. Narrative**

1. **Data Analysis:** (clusters of errors, causes, characteristics, and nature of each error)

Error Element: Ineligible cases due to excess resources, residency, household composition, excess earned income, unearned income, and nursing facility residency.

Nature: Failure to verify and request information.

2. **Program Analysis:** Describe the results of the program analysis including specific programmatic causes and root causes to which the errors were attributed.

Programmatic Causes: Case managers failed to follow proper policy and procedures.

Root Causes of Errors: Systemic staffing problems exacerbated by increased caseloads, and high staff turnover.

3. **Corrective Actions:** Identify the correction actions planned for major error causes. For each corrective action planned, describe the expected results: (1) target error causes; (2) the corrective actions planned to address the error causes; and (3) expected results.

- Conduct increased trainings on proper policy and procedures, including the need to verify and request information.
- Conduct Quality Control reviews on error-prone elements.

- Create an e-mail address for supervisors to identify and submit training needs on a monthly basis. Training needs will also be identified through Supervisory Review System (SRS) findings.
- Continue with Corrective Action Panel.

**4. Implementation and Monitoring:** Provide an implementation schedule for each corrective action. Provide a timeline including target dates, milestones and monitoring.

	<u>Action</u>	<u>Date Implemented</u>	<u>Expiration Date</u>
Completed Trainings	Community Medicaid	February 2010 March 2010 June 2010 September 2010 November 2010 December 2010	
	Long-Term Care	January 2010 June 2010 October 2010 February 2011	
	Long-Term Care/Nursing Home	October 2010	
	MCHP	January 2010 July 2010 October 2010 February 2011	
	DHR Quarterly Policy Briefing	March 2010 April 2010 September 2010 October 2010	
	Medicaid Expansion (each LDSS)	May 2010 June 2010	
	Medicaid Expansion Follow Up	July 2010 August 2010	
	Scheduled Trainings	Community Medicaid	March 9 – March 31, 2011 April 6 – April 30, 2011 June 8 – June 30, 2011
MCHP		May 18 – May 20, 2011	
Long-Term Care		May 11 – May 15, 2011	
	Targeted reviews (based upon PERM and SRS errors) by Quality Control.	October 2011	
	Creation of an e-mail address for supervisors to identify and submit training needs. The e-mail address will be monitored by the training division.	July 2011	
	Office of Eligibility Services (OES) will be	During next PERM review.	

<u>Action</u>	<u>Date Implemented</u>	<u>Expiration Date</u>
notified regarding all case records that cannot be located during PERM reviews. OES staff will follow up by telephone or conduct a site visit, if necessary, with local departments to locate the case records.		

5. **Evaluation:** Evaluate the effectiveness of the corrective action by assessing improvements in operations and/or less incidence of errors.

We expect that our error rate will decrease through increased training in error prone areas, by providing eligibility staff with clear current guidance and with the implementation of these corrective actions.

Example CAP

Payment Error Rate Measurement (PERM)  
Detailed Corrective Action Plan

A. State: XXXXXX

Fiscal Year: 2012

B. State Contact: XXXXXXXXX  
Phone Number: 999-888-2222  
Email address: stateemployee@dhs.state.XX.us

C. Program: Medicaid

D. Component: Eligibility

E. Narrative:

**1. Data Analysis:**

Error Element: Improper denials

Nature: Failure to evaluate for other Medicaid coverage

**2. Program Analysis:**

Programmatic Causes: No documentation of evaluation

Root Causes of Error: Caseworker failed to document that an evaluation for other Medicaid aid/program categories was completed when the individual was found to be ineligible for a specific Medicaid program; complicated policy.

**3. Corrective Actions:**

The State Medicaid Program Representatives will follow up with each county cited in error during the FY2010 PERM regarding corrective actions to determine whether any additional training is needed.

Medicaid Program Representatives will ensure that above-mentioned error findings are addressed with all counties.

Division of Medical Assistance staff will evaluate current Medicaid policy for simplification and make any necessary clarifications.

**4. Implementation and Monitoring:**

<u>Action</u>	<u>Date Implemented</u>	<u>Expiration Date</u>
Medicaid Program Representatives will provide training as needed	04/2010	On going
Medicaid Program Representatives follow up with counties on PERM FFY2007 errors	07/2010	07/2011
Simplify and clarify identified policy that is complex as needed	07/2010	On going

**5. Evaluation:**

Inform caseworkers of the policies and procedures for participation in the Medicaid Program, including the enrollment process, service coverage and limitations, claim and other form submission requirements, the processes to inquire about submitted claims and to request assistance, etc. The Program Integrity unit will verify that the provider communication and education plans and enhancements are executed by the Provider Services unit.

Payment Error Rate Measurement (PERM)  
Detailed Corrective Action Plan

A. State: XXXXXX Fiscal Year: 2012

B. State Contact: XXXXXXXXXXXX  
Phone Number: 999-888-2222  
Email address: stateemployee@dhs.state.XX.us

C. Program: Medicaid

D. Component: Eligibility

E. Narrative:

1. Data Analysis:

Error Element: Improper terminations

Nature: Failure to evaluate for other Medicaid coverage

2. Program Analysis:

Programmatic Causes: No documentation of evaluation for other Medicaid coverage

Root Causes of Error: Caseworker failed to document that an evaluation for other Medicaid aid/program categories was completed when the individual was found to be ineligible for a specific Medicaid program; complicated policy.

3. Corrective Actions:

The state Medicaid Program Representatives will follow up with each county cited in error during the FY2010 PERM regarding corrective actions to determine whether any additional training is needed.

Medicaid Program Representatives will ensure that above-mentioned error findings are addressed with all counties.

Division of Medical Assistance staff will evaluate current Medicaid policy for simplification and clarifications and make any necessary clarifications.

4. Implementation and Monitoring:

<u>Action</u>	<u>Date Implemented</u>	<u>Expiration Date</u>
Medicaid Program Representatives will	04/2010	

provide training as needed

Medicaid Program Representatives follow up with counties on PERM FFY2010 errors	07/2010	07/2011
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Simplify and clarify identified policy that is complex as needed	07/2010
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5. Evaluation:

Evaluation will consist of data analysis and assessment of the internal PERM reviews that will continue until the next federal review cycle commences. Errors and error trends are presented and discussed at each monthly meeting. Strategies will be evaluated based on reduction in similar errors. Modifications will be made to corrective action strategies, as appropriate, which may include improvements in operations and procedural efficiencies.

Example

Payment Error Rate Measurement (PERM)  
Evaluation of Previous Cycle's Corrective Action Plan

A. State XXXXXXXX Fiscal Year: 2011

B. State Contact: XXXXXXXXXX  
Phone Number: 999-888-2222  
Email Address: stateemployee@dhs.state.XX.us

C. Program (Medicaid or CHIP) Medicaid

D. Component (fee-for-service, managed care, eligibility) Fee-for-Service

E. Narrative:

- Correction Action:  
MR 1 - Failure to provide medical records.  
MR2 errors – Insufficient documentation
  
- Implementation Schedule
  - Target Dates:  
Summer 20XX for Provider Newsletter  
Provider PERM Error Letters: August 20XX to Present  
Overpayment Identification and Recovery Contract – April 1, 20XX kick-off date
  - Actual Dates:  
Fall 20XX Provider Newsletter released  
Provider PERM Error Letters: September 20XX to Present  
Overpayment identification and Recovery Contract – delayed due to funding
  - Monitoring:  
On-going Program Integrity Reviews  
Monthly QIO reviews  
On-going data mining by Program Integrity

- Monitoring: On-going
- Milestones: Reduction in errors resulting from PERM medical records review as well as technical denial rates by the QIO.
  
- Evaluation Summary

Educating and sensitizing providers to the PERM review process as well as added staffing hours to communicate and track requests for provider documentation yield the desired results of a decrease in medical documentation errors during the current review measurement saving both the agency and provider time and resources. We were able to reduce the prior year's overall claim error rate by 50% or with an error rate less than 3%.

Example

**Payment Error Rate Measurement (PERM)  
Evaluation of Previous Cycle's Corrective Action Plan**

A. **State:** XXXXXXXX **Fiscal Year:** 2012

B. **State Contact:** XXXXXXXX  
**Phone Number:** 999-888-2222  
**Email Address:** stateemployee@dhs.state.XX.us

C. **Program:** Medicaid

D. **Component:** Eligibility

E. **Narrative**

- **Corrective Actions:** Ineligible cases due to excess resources, residency, household composition, excess earned income, unearned income, and nursing facility residency.
  
- **Implementation:**

	<u>Action</u>	<u>Anticipated Implementation Date</u>	<u>Actual Date Implemented</u>
Trainings	Community Medicaid	February 2010 March 2010 June 2010 September 2010 November 2010 December 2010	April 2010 May 2010 August 2010 November 2010 January 2011 February 2011
	Long-Term Care	January 2010 June 2010 October 2010 February 2011	March 2010 August 2010 December 2010 April 2011
	Long-Term Care/Nursing Home	October 2010	December 2010
	MCHP	January 2010 July 2010 October 2010 February 2011	March 2010 September 2010 December 2010 April 2011
	DHR Quarterly Policy Briefing	March 2010 April 2010 September 2010 October 2010	May 2010 June 2010 November 2010 December 2010

<u>Action</u>		<u>Anticipated Implementation Date</u>	<u>Actual Date Implemented</u>
	Medicaid Expansion (each LDSS)	May 2010 June 2010	July 2010 August 2010
	Medicaid Expansion Follow Up	July 2010 August 2010	September 2010 October 2010
Scheduled Trainings	Community Medicaid	March 9 – March 31, 2011 April 6 – April 30, 2011 June 8 – June 30, 2011	May 9 – May 31, 2011 June 6 – June 30, 2011 August 8 – August 30, 2011
	MCHP	May 18 – May 20, 2011	July 18 – July 20, 2011
	Long-Term Care	May 11 – May 15, 2011	July 11 – July 15, 2011
Targeted reviews (based upon PERM and SRS errors) by Quality Control.		October 2011	December 2011
Creation of an e-mail address for supervisors to identify and submit training needs. The e-mail address will be monitored by the training division.		July 2011	August 2011
Office of Eligibility Services (OES) will be notified regarding all case records that cannot be located during PERM reviews. OES staff will follow up by telephone or conduct a site visit, if necessary, with local departments to locate the case records.		During next PERM review.	During next PERM review

- **Evaluation:** Evaluate the effectiveness of the corrective action by assessing improvements in operations and/or less incidence of errors.

The actual implementation dates were delayed for two months due to a delay in the preparation of training materials. We were able to decrease our error rate through the increased training in error prone areas and by providing eligibility staff with clear current guidance.