



# Payment Error Rate Measurement (PERM)

October 2011

Centers for Medicare & Medicaid Services



# Agenda

- History and overview
- Methodology
- Roles and responsibilities
- Differences between FY2009 and FY2012 cycles
- FY2012 process details
- Communication and collaboration
- Contact information

# History and Overview

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

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

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

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

# Expansion and Refinement of the PERM Program

- In FY 2007 CMS expanded the methodology to measure the accuracy of Medicaid managed care payments, CHIP FFS and managed care payments, and Medicaid and CHIP eligibility decisions
- In 2009 Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - Required changes to the PERM methodology
  - Postponed CHIP measurement until new rules could be issued
- New PERM regulation, effective September 10, 2010, creates differences between FY 2009 and FY 2012

# Continuing Evolution of the PERM Program

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

# PERM Methodology Overview

# Measuring Payment Errors in Medicaid and CHIP

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

# Sampling Overview

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

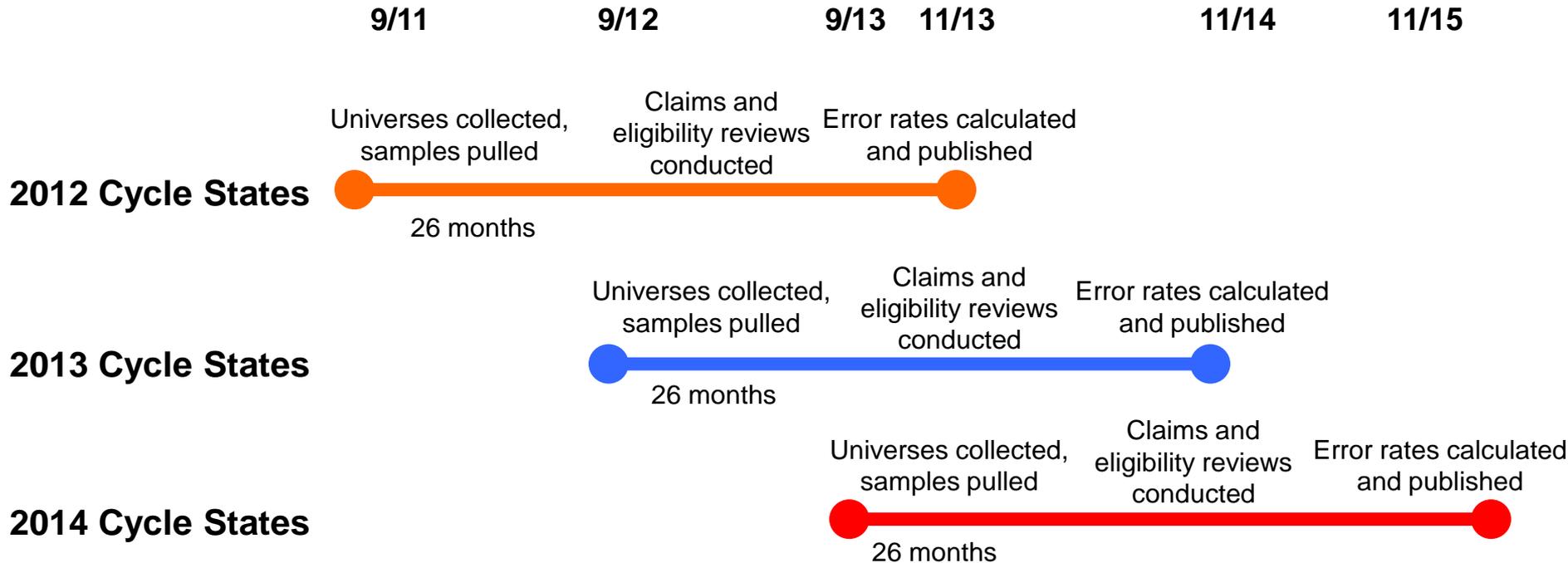
# PERM State Rotation

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

# PERM Cycle Progression

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

# PERM Cycle Progression



# Roles and Responsibilities

# PERM Roles and Responsibilities

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

# CMS PERM Team Responsibilities

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

# CMS PERM Team Responsibilities

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

# State Responsibilities

- Provide a representative to spearhead PERM
- Provide claims data to Statistical Contractor
- Educate providers on PERM process
- Assist Review Contractor with on-site and/or remote data processing reviews
- Request difference resolution/appeals for differences
- Conduct eligibility reviews
- Participate in cycle calls with CMS
- Develop and implement corrective actions to reduce improper payments

# Statistical Contractor Responsibilities

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

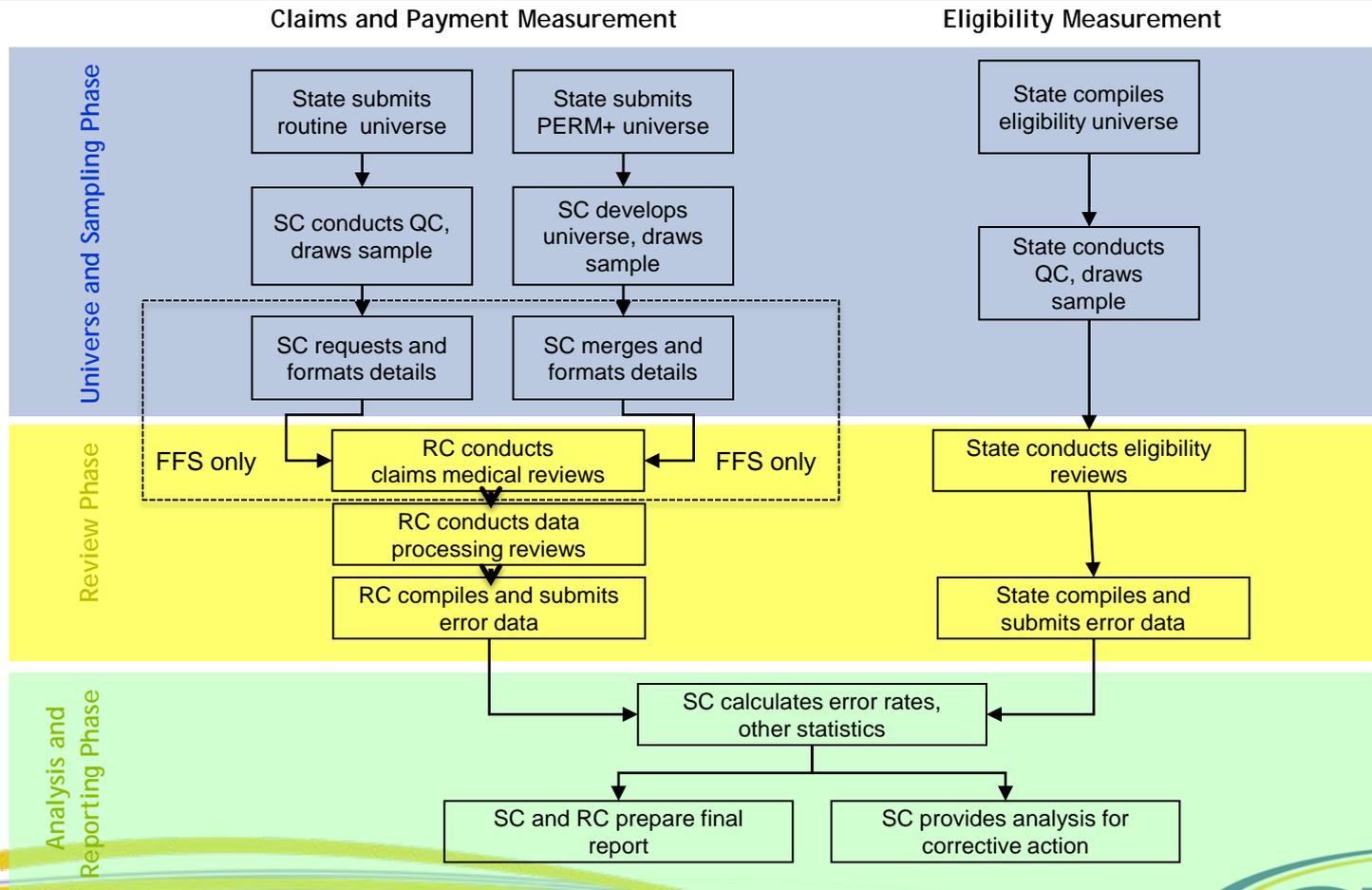
# Statistical Contractor Responsibilities

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

# Review Contractor Responsibilities

- Collects state policies
- Requests medical records
- Conducts data processing reviews on all sampled payments
- Conducts medical/coding reviews on relevant sampled payments
- Maintains a website with a state portal to track activities and findings
- Reviews requests for difference resolution
- Assists in preparing final report

# PERM Cycle Progression



**PERM 2012:**

# **Differences Between FY2009 and FY2012 Cycles**

# Changes to PERM Since the Last Cycle

- Final PERM regulation published in 2010
  - Made several changes to the PERM methodology
  - CMS has also continued to refine the operational approach
- Two big changes:
  - CHIP measurement is no longer on hold; will be included in 2012
  - There are only two PERM contractors now (SC and RC)
- Many other changes that affect data submission, stratification, review, and CAPs

# Differences between FY 2009 and FY 2012 PERM Cycles: Data/Statistical Process

FFY 2009	FFY 2012
States had to break aggregate payments into beneficiary-specific records for submission	States may be able to submit some aggregate payments in their aggregate form
One data submission method for all states	Two data submission methods – states can either submit data using the new PERM+ process or continue routine PERM submission
Same sample sizes for all states	State-specific Medicaid sample sizes for each component; Base sample sizes for CHIP
States had to submit adjustments made within 60 days of original paid date	Review Contractor will collect adjustments during DP review

# Differences between FY 2009 and FY 2012 PERM Cycles: Review Process

FFY 2009	FFY 2012
Providers had 60 days to submit records	Providers have 75 days to submit records
No option for electronic submission of medical records for providers	Providers may submit medical records electronically
DP and medical review conducted on \$0 paid claims	DP review only for \$0 paid claims
\$0 errors coded as errors	\$0 errors will be coded as deficiencies

# Differences between FY 2009 and FY 2012 PERM Cycles: DR/Appeal Process

FFY 2009	FFY 2012
States had 10 business days to file DR requests and 5 business days for appeal requests	States now have 20 business days to file DR requests and 10 business days for appeal requests
Old re-pricing process	New re-pricing process
States could only appeal errors where the difference in findings was over \$100	States can appeal any error

# Differences between FY 2009 and FY 2012 PERM Cycles: Eligibility

FFY 2009	FFY 2012
Errors based on self declared information are considered errors	Errors based on self declared information are no longer errors
Definition of a “case” is different between PERM and MEQC	Definition of a “case” same as MEQC definition
Eligibility universes must be stratified into three strata	PERM stratification is optional
States must calculate and report eligibility error rates	States no longer required to calculate their own error rates

# PERM 2012: Process Details

# Statistical Contractor: Universe Collection and Sampling

- PERM independently samples payments from four universes or program areas
  - Medicaid FFS
  - CHIP FFS
  - Medicaid managed care
  - CHIP managed care
- Beginning in FY12, each program area is divided into strata based on service type
  - Eleven total strata will be used – 10 service type strata and 1 stratum for Medicare Premiums

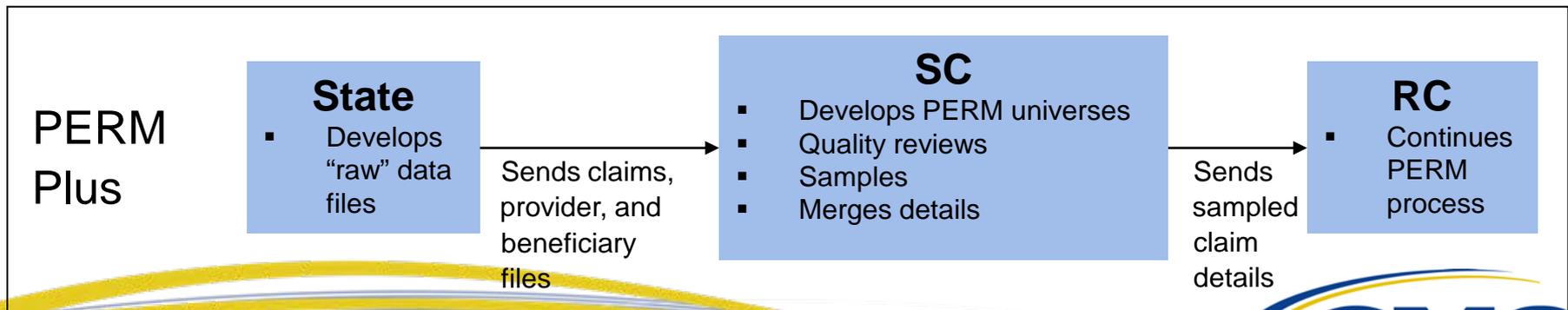
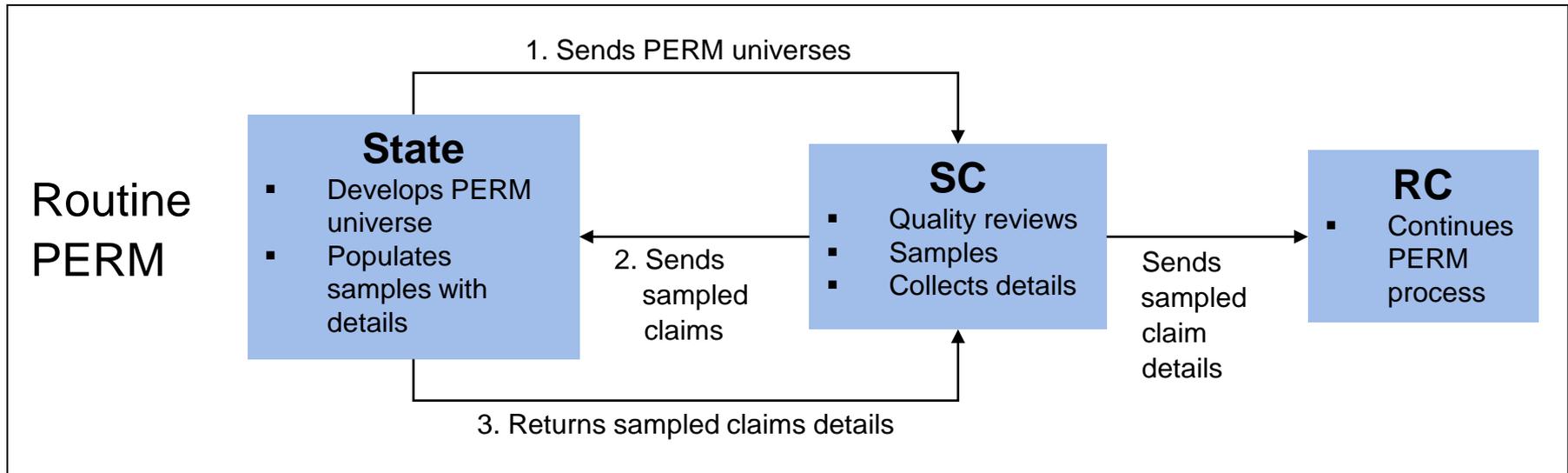
# Statistical Contractor: Universe Collection

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

# Statistical Contractor: State-Specific Sample Sizes

- The Statistical Contractor will calculate state-specific sample sizes for each claims component for each state
  - FFS
  - Managed care
- Because Cycle 1 did not have a CHIP measurement in FY09, the base sample sizes will apply:
  - 540 claims for FFS
  - 280 claims for managed care

# Statistical Contractor: Universe Collection and Sampling



# Statistical Contractor: Error Rate Calculation

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

# Review Contractor: Collection of State Policies

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

# Review Contractor: Medical Record Requests

- Uses provider information from data files submitted by states
- Initial call to provider to verify provider information
  - State support needed for incorrect/non-current contact information
- Initial request sent to provider
  - Detailed documentation request list provided for each claim category sampled

# Review Contractor: Medical Record Requests

- Providers have 75 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
- 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

# 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 (on-site or remote)
  - Collection of all state policies and manuals needed for DP review
  - Establish state contacts, working protocols and start dates for reviews

# Review Contractor: DP Review

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

# Review Contractor: Medical/Coding Reviews

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

# Review Contractor: Medical/Coding Reviews

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

# Review Contractor: RC Website

- Tracks all reviews, receipt of medical records 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 reports, file for Difference Resolution and CMS appeals
- Training and access provided during the month when reviews begin
- Access limited to states, contractors and CMS through password protection

# Eligibility Review Process

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

# Eligibility Review Process

- Revised eligibility instructions on CMS website
  - [http://www.cms.gov/PERM/09\\_PERM\\_and\\_MEQC\\_Eligibility\\_Measurements.asp#TopOfPage](http://www.cms.gov/PERM/09_PERM_and_MEQC_Eligibility_Measurements.asp#TopOfPage)
- Relevant changes:
  - Section related to CHIPRA
  - Exclusion of Express Lane Eligibility Cases
  - Guidance on MEQC data substitution
  - Expanded acceptable self declaration and introduced guidance on passive renewal
- Sampling plans were due August 1, 2011

# Eligibility Review Process

- Orientation to PERM eligibility reporting website held on September 22
  - <https://www.cmspett.org/index.php>
- First monthly sample submission due November 15th

# Communication and Collaboration

# Communication and Collaboration

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

# CMS Contact Information

## **FY 2012 Cycle Manager**

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