

# Payment Error Rate Measurement (PERM) Update

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September 14, 2010

# What We Will Cover

- Improper Payment Measurement Requirements
- PERM Final Regulation
- Findings
- Program Updates

# Improper Payment Measurement Requirements

- IPIA (Improper Payment Information Act of 2002) - amended in July 2010 by Improper Payments Elimination and Recovery Act (IPERA).
  - Designed to improve agency efforts to reduce and recover improper payments
  - Assess program for risk of making improper payments; estimate and report these amounts annually; and take corrective actions.
  - Expands the types of programs that are required to conduct payment recovery audits
  - Authorizes agency heads to use recovered funds for additional uses
  - Defines actions to be in compliance and actions if not in compliance

# Improper Payment Measurement Requirements

- Executive Order 13520 – Reducing Improper Payments (November 20, 2009)
  - Aimed at further intensifying efforts to eliminate payment error, waste, fraud, and abuse in federal programs
  - Adopts a comprehensive set of policies that include:
    - Transparency and public scrutiny of significant payment errors
    - Focus on identifying and eliminating the highest improper payments
    - Agency accountability for reducing improper payments
    - Coordinated federal, state, and local government action in identifying and eliminating improper payments
  - Added new requirements for:
    - Supplemental measurement of high risk areas
    - Reporting on treasury payment accuracy website
    - Reporting comprehensive improper payment measurement and reduction activities to OIG
    - Reporting on high dollar overpayments and outstanding debts

# PERM IPERA Activities and Milestones

- IPERA Activities
  - Reporting results of 2009 cycle States in November 2010.
  - HHS will report a rolling rate for Medicaid in the November 2010 AFR. This rolling rate will be an average of states measured over the past 3 years.
  - Beginning reviews for 2010 cycle States; reporting results in November 2011.
  - Conducting outreach sessions to start 2011 cycle States.
- IPERA Milestones
  - **on or about November 15, 2010** -- report improper payment information in DHHS AFR and CMS Financial Report

# PERM EO Activities and Milestones

- Activities
  - Develop supplemental improper payment measures for high risk areas
    - Medicaid supplemental measure improves utilization of PERM findings and other measures to foster improvements in Medicaid program integrity nationally.
    - CMS' Medicaid Integrity Group is leading the cluster measurement project.
  - Provide improper payment information for:
    - Treasury payment accuracy website launched on June 29 and is available at [www.paymentaccuracy.gov](http://www.paymentaccuracy.gov).
    - New OIG reporting requirements

# PERM Final Rule

- Section 601 of CHIPRA required a new final rule implementing PERM requirements.
- CHIPRA prevented CMS from continuing with ongoing CHIP measurements.
- CMS could not publish a CHIP error rate until 6 months after the final rule was in effect.
- CMS published the PERM rule on August 10, 2010. The regulation is located at <https://www.cms.gov/PERM>.
- CHIP is restarting for FY 2011. The next CHIP error rate will be reported in 2013.
- 07 and 08 States can opt to reject their first CHIP error rate. A SHO letter was sent on August 20 giving them the option.

# PERM Final Rule

## Major Changes

Topic	Previous Policy	New Policy Based on Final Regulation	Notes	Cycle Impact
Sample size - claims and eligibility	No maximum sample size	The maximum sample size is set at 1,000 claims or cases for each component	Because reviewing claims requires both staff and monetary resources, a maximum sample size puts a limit on expenditures.	FY11 and beyond
Sample size - claims and eligibility	Each state had the same sample size for each component of the measurement	Beginning in FY 2011, state-specific sample sizes will be calculated based on the prior year's component-level error rates	CMS' Statistical Contractor will calculate each state's sample size for each component. If states choose to reject their FY07 or FY08 CHIP error rates, the state's sample size in the next cycle will be the base year sample size.	FY11 and beyond
Review process - claims	Providers must submit documentation within 60 days	Providers must submit documentation within 75 days	CMS changed policy based on comments on original policy	FY10 and beyond
Difference resolution - claims	Appeals to CMS needed to be on errors in the amount of \$100 or more	States can now appeal errors below \$100	All errors regardless of their dollar amount ultimately contribute to a state's error rate and hence the national error rate	FY10 and beyond
Difference resolution - claims	States had 10 business days to request difference resolution and 5 business days to request an appeal	States now have 20 business days to request a difference resolution and 10 business days to request an appeal to CMS	CMS changed policy based on comments on original policy.	FY10 and beyond

# PERM Final Rule

## Major Changes Continued

Topic	Previous Policy	New Policy Based on Final Regulation	Notes	Cycle Impact
Self-declaration - eligibility	States were required to verify items that were self-declared	States can accept current self-declaration documentation in the case file	Self-declaration statement must be: <ul style="list-style-type: none"> <li>Present in the record</li> <li>Not outdated (more than 12 months old)</li> <li>In a valid, state-approved format</li> <li>Consistent with other facts in the case record</li> </ul>	FY10 and beyond
Difference resolution - eligibility	No eligibility appeals process	There is a defined process for states to appeal eligibility errors  Appeals for eligibility review findings should be conducted in accordance with the state's appeal process, as eligibility reviews are conducted at the state level	For states that may not have a state appeals process in place, CMS will: <ul style="list-style-type: none"> <li>make state findings available to each respective state's Medicaid and CHIP agency</li> <li>facilitate documentation exchange between the state Medicaid or CHIP agency and the agency conducting the PERM eligibility reviews to resolve differences</li> <li>address appeals if any eligibility appeals issues involve federal policy</li> </ul>	FY10 and beyond
PERM/MEQC harmonization - eligibility	N/A	CHIPRA allows states to use traditional MEQC to replace PERM in a state's given PERM cycle; the new PERM regulation allows states to use PERM to replace MEQC as of the publication of the new rule	The PERM regulation and forthcoming revised PERM guidelines provides states with additional detail on PERM/MEQC harmonization.	FY09 for MEQC for PERM FY11 for PERM for MEQC

# PERM Final Rule

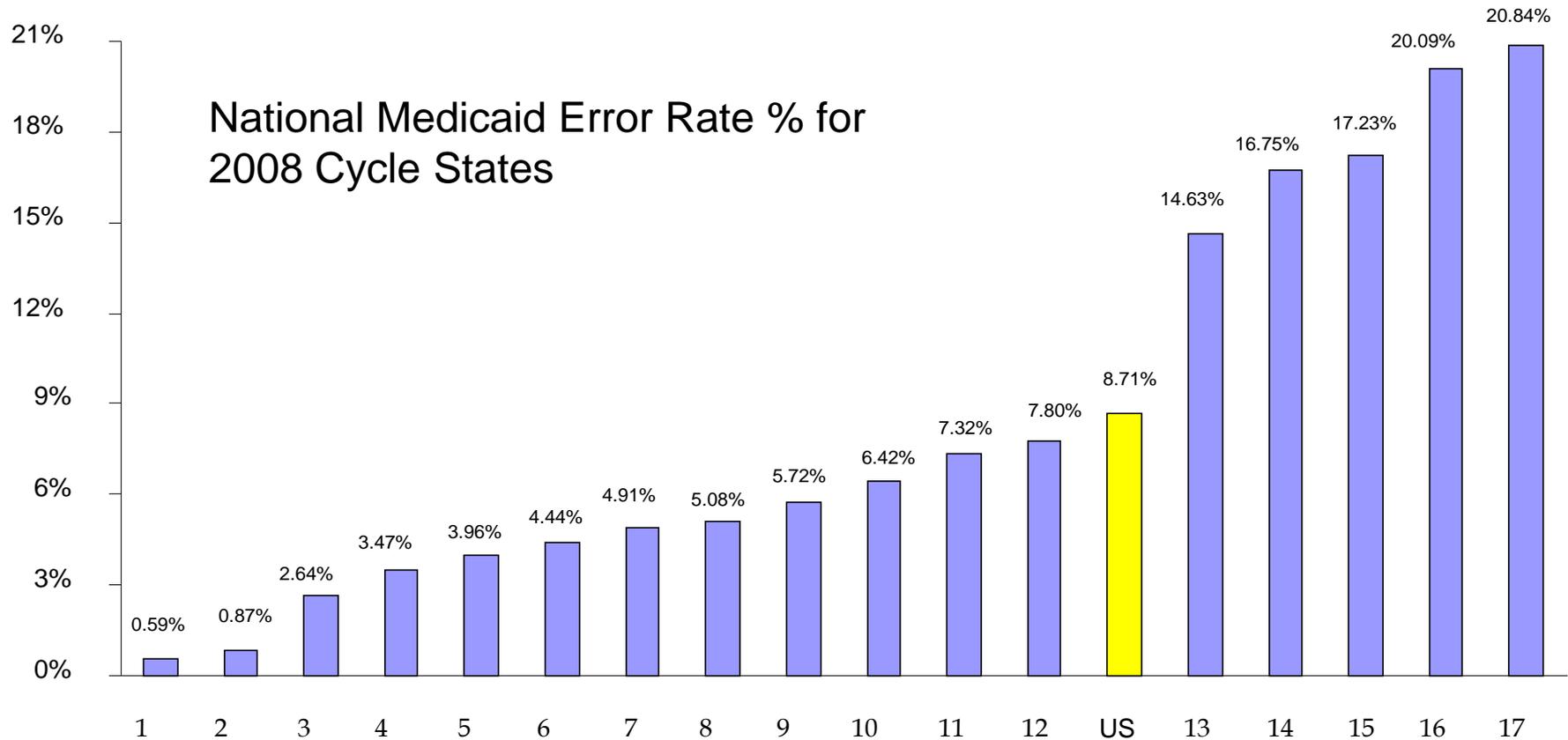
## Major Changes Continued

Topic	Previous Policy	New Policy Based on Final Regulation	Notes	Cycle Impact
Sampling unit - eligibility	“Case” was defined as an individual	“Case” now defined as an individual or family	States can use either definition; universe totals will need to reflect the sampling unit used by the state	FY11 and beyond
Error rate calculation - eligibility	States were required to calculate their eligibility error rates	The SC will calculate eligibility error rates	States will be required to submit data (rather than error rates) by July 1	FY10 and beyond
Universe - eligibility	Active cases needed to be stratified	States have the option to stratify active cases or not stratify active cases	CMS changed policy based on comments on original policy	FY11 and beyond

# PERM Findings

Fiscal Year Measurement	Overall	Fee For Service	Managed Care	Eligibility with Undetermined	Eligibility Without Undetermined
Medicaid 2006*	4.7%	4.7%	N/A	N/A	N/A
Medicaid 2007	10.5%	8.9%	3.1%	2.9%	2.4%
CHIP 2007	14.7%	11.0%	0.1%	11.0%	2.7%
Medicaid 2008	8.7%	2.6%	0.1%	6.7%	3.9%

# Findings Across the First Three Cycles: Significant Variation in Error Rates



# Findings Across the First Three Cycles: Significant Variation in Error Rates

- Across states and across cycles, there are significant differences in payment error rates.
- Results from multiple factors related to differences in how states implement and administer their programs
  - E.g., states with proportionately larger managed care programs are likely to have lower overall error rates
- Important next steps for CMS and the states will be:
  - Identifying the drivers of these differences at the state and federal levels
  - Working to reduce improper payments at the state level, especially given the EO requirements
  - Further refining the PERM methodology to ensure that allowable differences in state policies and administration are not contributing to inappropriate differences in error rates

# Findings Across the First Three Cycles: There Are Few Claims Processing Errors, Many Documentation Errors

- State Medicaid claims processing systems appear to make most individual payments accurately, with very few data processing errors detected in any of the first three PERM cycles
  - Many of the data processing errors identified were pricing errors, where the amount paid was different from the amount that should have been paid, but the claim itself was not in error
  - Most other data processing errors are due to non-covered service errors where the service is not covered by Medicaid or the provider is not registered or licensed according to regulation
- Insufficient documentation and no documentation errors have been a large contributor to the error rate; however, these errors are decreasing.
  - This decrease may be caused by the increase in provider knowledge about the PERM process and provider responsibilities.

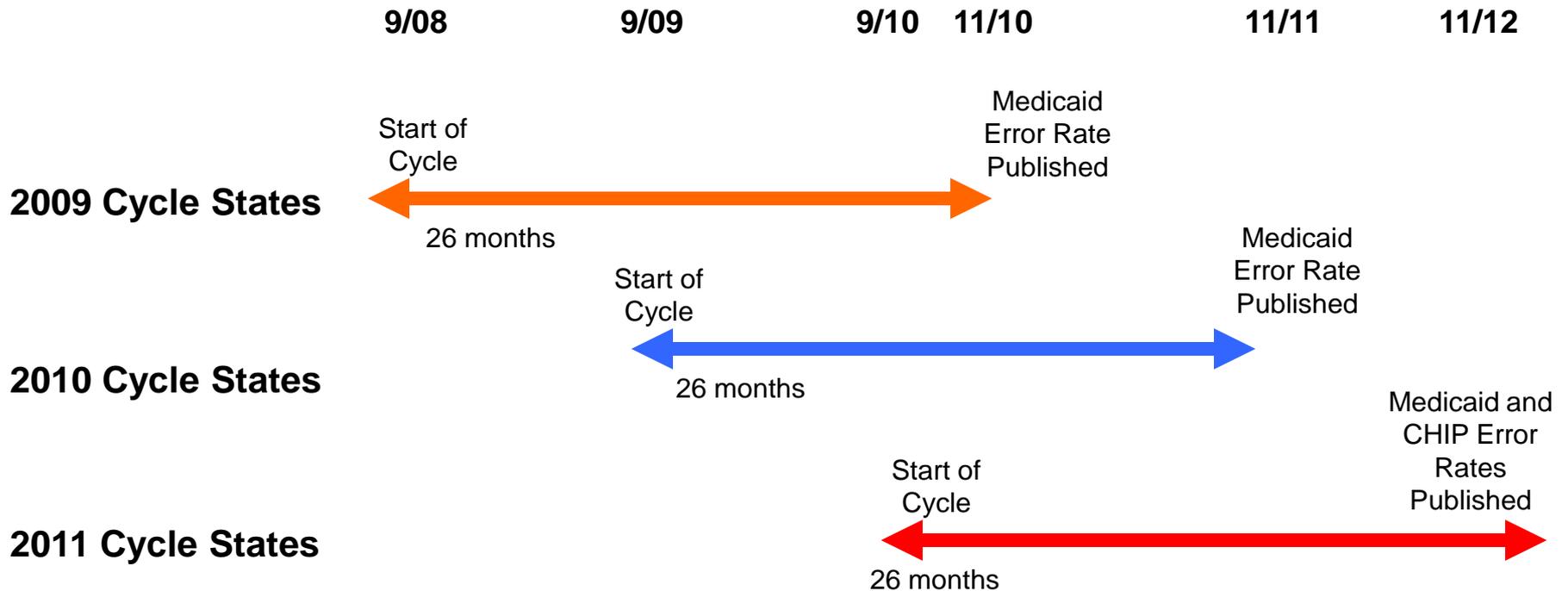
# Findings Across the First Three Cycles: There Are Few Underpayment Errors

- While the PERM error rates consider both underpayments and overpayments as “improper,” underpayments account for a substantially smaller proportion of payment errors than overpayments
  - Average less than 10% of projected dollars in error each year
- States do not appear to be systematically denying claims improperly

# Findings Across the First Three Cycles: Few Managed Care Errors, Many Eligibility Errors

- States make vastly fewer errors processing managed care payments than fee-for-service payments
  - This would be expected, as the number of payees for managed care is smaller—typically a few health plans versus thousands of individual providers for FFS—and the types of payments made are less varied—typically a few dozen all-inclusive rates for managed care, versus individual fees for thousands of different services and procedures in FFS)
- Eligibility errors contribute significantly to the Medicaid payment error rate
  - Eligibility errors include both errors due to beneficiaries who are receiving services but are not eligible and beneficiaries for whom states are not able to definitively determine eligibility

# PERM Program Updates



# PERM Program Updates

- Increasing Communication and Information Sharing:
  - PERM Manual
  - Provider Education Efforts
  - State Systems Workgroup
  - Best Practices Calls
  - TAG
- Decreasing State Burden:
  - PERM+
  - Aggregate Payment Pilot
  - State Policy Database
- Continuing to work with our partners to eliminate redundancies and improve the process.

# For More Information....

- General Questions, Contact Cindy D'Annunzio, 410-786-1878, [Cynthia.dannunzio@cms.hhs.gov](mailto:Cynthia.dannunzio@cms.hhs.gov)
- Cycle Questions, Contact the Cycle Managers:
  - 2010 Cycle – Stacey Carroll, 410-786-0241, [stacey.carroll@cms.hhs.gov](mailto:stacey.carroll@cms.hhs.gov)
  - 2011 Cycle – Nicole Perry, 410-786-8786, [nicole.perry@cms.hhs.gov](mailto:nicole.perry@cms.hhs.gov)
- Visit the PERM website at [www.cms.gov/perm](http://www.cms.gov/perm)
- Questions?

