Payment Error Rate Measurement/ Medicaid Eligibility Quality Control

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What We Will Cover

- Improper Payment Measurement Requirements
- PERM Overview
- PERM Final Rule
- PERM Eligibility Review Under Final Rule
- MEQC

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 used 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 Overview

- CMS uses a 17-state rotation for PERM. Each state is reviewed once every three years. This rotation allows states to plan for the reviews as they know in advance when they will be measured.

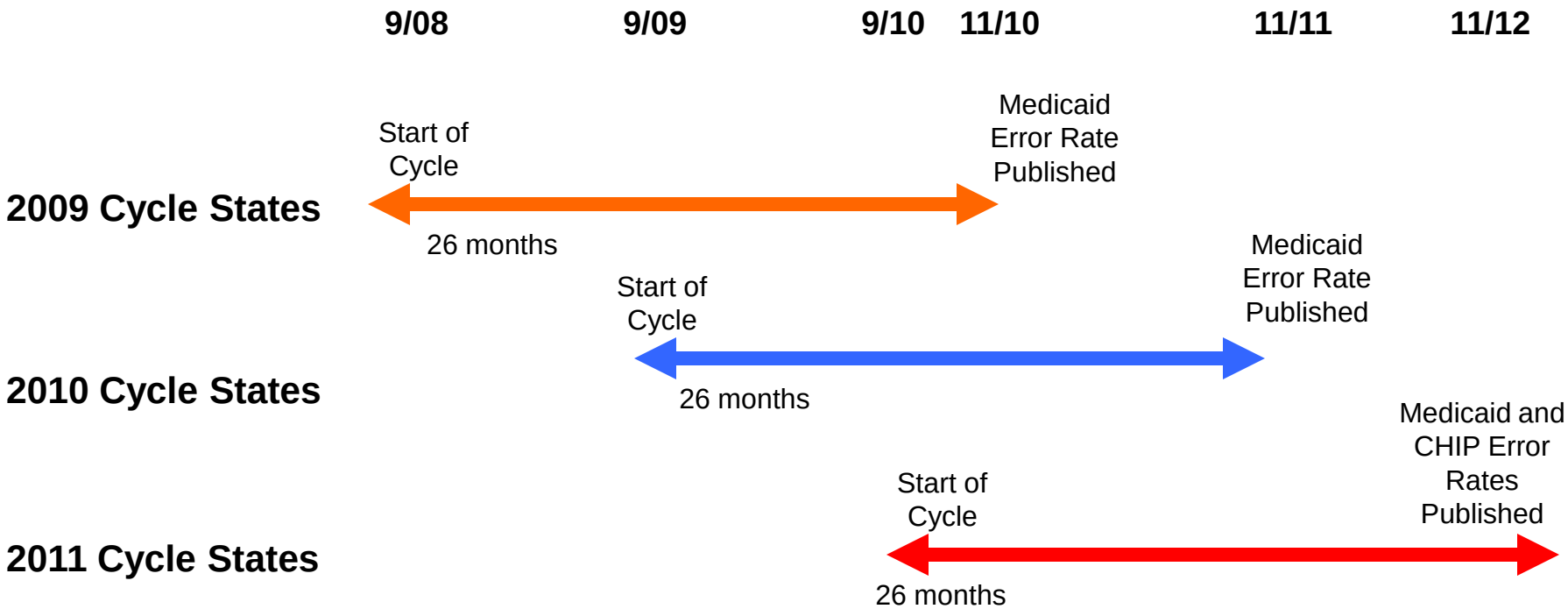
States by Measurement Cycle	
2009 Cycle	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
2010 Cycle	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
2011 Cycle	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

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 IPERA Activities and Milestones



PERM Overview
Components & Sample Sizes

- Medicaid
  - FFS: 500 line items annually (samples selected quarterly)
  - Managed Care: 250 capitation payments annually (samples selected quarterly)
  - Eligibility: 504 active cases, 204 negative cases annually (samples selected monthly)

- CHIP
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PERM Overview
PERM Eligibility Component

- Eligibility component has four phases:
  - Sampling
  - Eligibility Reviews
  - Payment Reviews
  - Error Rate Calculation
- States perform their own eligibility reviews according to State and Federal eligibility criteria.
- States measure Medicaid and CHIP separately and must review active and negative cases. Negative cases are all cases denied or terminated from the programs.
- The eligibility component produces its own error rates:
  - Active case error rate
  - Negative case error rate
  - Active case payment error rate

- The eligibility payment error rate is included into the national program error rate with FFS and managed care error rates.

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: Sampling and Review

- **Definition of a case**: Individual or family enrolled in or denied or terminated from Medicaid or CHIP.
- **Maximum sample size**: 1,000 active cases, 1,000 negative cases, depending on State-specific error rate from previous cycle.
- Express Lane Eligibility cases excluded from universe.
- Stratification is optional.
- Self-Declaration: States can accept current self-declaration documentation in the case file.
- Self-Declaration must be (when applicable):
  - Present in the case record,
  - Not outdated (not more than 12 months old),
  - Originating from the last case action,
  - In a valid, State-approved format,
  - Consistent with other facts in the case record.

PERM Final Rule: Eligibility Appeals

- Appeals for eligibility review findings should be conducted in accordance with the States' established appeals process.
- If one does not exist at the State level, CMS will:
  - Allow State findings be made available to each respective States' Medicaid and CHIP agency,
  - Facilitate documentation exchange when necessary
- CMS will only directly address eligibility appeals that involve interpretation of Federal policy.

PERM Final Rule: MEQC Data Substitution

- CHIPRA allows States to use data from the administration of their "traditional" MEQC reviews and substitute it for PERM reviews.
- States conducting MEQC pilots may not submit pilot data for PERM reviews.
- States will work with CMS' statistical contractor to develop the appropriate sample size.
- No PERM stratification is necessary, but must identify the last case action for each sampled case.
- MEQC error rate and PERM error rate will be calculated separately based on the calculations for each program.
- States may conduct both traditional MEQC reviews and PERM reviews, if desired.

PERM Final Rule: PERM Data Substitution

- States may use PERM eligibility data and substitute it for MEQC “traditional” reviews.
- States that substitute PERM data will need to submit a State Plan Amendment referencing PERM rule.
- States must submit the approved PERM sampling plan to the CMS regional office.
- Reports will appear on the PERM eligibility reporting website as usual.
- MEQC error rate and PERM error rate will be calculated separately based on the calculations for each program.
- Error findings will be shared with the CMS regional office.
- Disallowances will apply to the lower limit of the MEQC error rate.

2011 Eligibility Review Guidance

- More streamlined instructions.
- Expanded background section including a discussion of CHIPRA.
- Revised sampling plan requirements.
- Stratification moved to an appendix.
- Additional section for eligibility appeals.
- Substitution guidance.
- Revised reporting on PERM eligibility website.

2011 Eligibility Review Guidance

- States submit random samples each month, review each sampled case for eligibility, then collect payments for services received in the sample month.
- States must submit all monthly findings to CMS according to the eligibility timeline.
- States will have the option to either maintain stratification or sample from an unstratified universe.
- The last action must be identified, either through stratification, or post sample identification.
- Report the total number of cases in the universe, or within each stratum universe.

2011 Eligibility Review Guidance

- Previous PERM eligibility rules defined a “case” as an individual
  - A family/household/application-level case had to be broken into individuals for purposes of sampling
- New rules allow a PERM case to be either individual persons (as before) or family/application level
  - Family/application cases would include both individuals (case of 1) and families (case of 2 or more)
- All payments associated with the case would be collected
  - Only payments associated with any ineligible persons within the case would be considered dollars in error

2011 Eligibility Review Process

- Examine the evidence in the case record.
- Re-verify information where evidence is:
  - Missing,
  - Outdated,
  - Inconsistent with other facts in the record, or
  - Unacceptable under self declaration guidelines.
- Self declaration statements are acceptable evidence for the reviews as long as State policy and procedure was followed.
- If the self declaration in the record is not acceptable, self declared information can be verified with a new self declaration statement or third party sources.
- If the agency cannot verify eligibility or confirm ineligibility, the case is undetermined.

Medicaid Eligibility Quality Control (MEQC)
Subpart P – Quality Control 42 CFR 431.800 – 431.865

- Federal Medicaid regulation
  - In the early 1970s states estimated through statistical sampling the percentage of ineligible persons and acted to reduce the percentage
  - June 1975, HHS issue regulations required states to initiate another quality control applying only to eligibility which was replaced by MQC in 1978
  - February 1984, Section 133 of Tax Equity and Fiscal Responsibility Act of 1982 provided for disallowances of FFP to states who eligibility payment error rate for Medicaid exceeded a new 3% national standard established by Congress (allowed to be prospective, based on projected error rate)
  - May 1990, the final rule BQC-21 published revised the regulations governing MEQC
  - Medicaid State Operations Letters #95-58 and #94-29 gave states the opportunity to do MEQC pilots

Basic elements of MEQC system

- The state must:
  - Operate in accordance with the polices, sampling methodology, review procedures, reporting forms and requirements specified by CMS
  - Select statistical samples of both active and negative case actions
  - Review each case in the sample to identify eligibility errors
  - Review any claims pertaining to each active case to identify erroneous payments resulting from
    - Ineligibility
    - Recipient liability understated or overstated
    - Third –party liability
    - Claims processing errors
  - Conduct field investigation
  - Use 6 month sampling periods, April – September and October – March
  - Submit reports to CMS in form and time specified

Traditional MEQC Sampling Plan Guidelines

As referenced in State Medicaid Manual 7130, the plan must include:

- The population to be sampled;
- The list(s) from which the sample is selected;
- The sample size;
- The sample selection procedure;
- The claims collection procedure;
- The option to drop/not drop cases selected more than once in the sample period;
- The option to use paid claims, billed amounts, and denied claims to offset beneficiary liability in the eligibility review; and
- The option to divide multiple service-month claim amounts by associated months of service, or use the date the service was terminated to determine the service month for the entire claim amount.

Pilot MEQC Guidelines

- Goal: Must focus on error prevention, reduction in Medicaid errors or erroneous expenditures or improved program administration
- Pilots are not limited to Medicaid eligibility
- Do not need to be applied on a Statewide basis
- Pilots can not be used to determine client satisfaction, outreach efforts, the efficiency of managed care delivery systems or other program areas unless it results in a form of error prevention or reduction.
- Pilots can not be used to monitor the activities of Medicaid negative case actions or other program (TANF, SNAP, CHIP)
- Pilots any length up to 12 months , proposal must be submitted at least 60 days before the planned implementation date
- Pilots should be submitted to the appropriate Regional office with a CC to Central Office (monetha.dockery@cms.hhs.gov)
- States reviewing the same focus as the previous year, continuation must deviate from previous year to provide new information
- Maintenance of effort: States must demonstrate how workload meets full maintenance of effort.
- Approvals and denials should be in writing.

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Minimum Sampling Requirements for Pilots

- The review methodology
  - What you are reviewing and how
- Describe the sampling timeframe
  - October through September and/or the timeframe that each case is reviewed
- Describe your universe of sampling units
  - Mainframe file, CD
- Sample Size
  - How many units in the sample
- Method of selection,
  - e.g. systematic random sample
- How the sample is drawn
  - How are the random numbers selected
- Description on how maintenance of effort is arrived at
  - Based on hours involved in completing the traditional MEQC reviews
- Description of how summary reports will be create
  - What information will be presented

MEQC Traditional vs. Pilots for FY 2010

Region 1	• Traditional – Connecticut, Vermont, Maine, Rhode Island • Pilot – Massachusetts, (1115 Waiver), New Hampshire
Region 2	• Traditional – New Jersey • Pilot – New York (1115 Waiver)
Region 3	• Traditional - Delaware • Pilot – Pennsylvania, Maryland, West Virginia, District of Columbia, Virginia
Region 4	• Traditional – Alabama, Mississippi • Pilot – Georgia, Kentucky, South Carolina, Tennessee, Florida, North Carolina
Region 5	• Traditional - Michigan • Pilot – Illinois, Indiana, Minnesota, Ohio, Wisconsin

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MEQC Traditional vs. Pilots for FY 2010

Region 6	• Traditional - Oklahoma • Pilot – Arkansas, New Mexico, Louisiana, Texas
Region 7	• Traditional - None • Pilot – Kansas, Iowa, Nebraska, Missouri
Region 8	• Traditional – North Dakota • Pilot – Wyoming, Colorado, Utah, Montana, South Dakota
Region 9	• Traditional - Nevada • Pilot – California, Arizona (1115 Waiver), Hawaii (1115 Waiver)
Region 10	• Traditional - None • Pilot – Idaho, Alaska, Oregon, Washington

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CMS Regional Office MEQC Contacts

Region	Contact	Email	Phone
1	Marie Montemagno	Marie.Montemagno@cms.hhs.gov	617.565.1227
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4	Rita Nimmons	Rita.Nimmons@cms.hhs.gov	404.562.7415
5	Twana Brown	Twana.Brown@cms.hhs.gov	312.353.3851
6	Suzette Seng	Suzette.Seng@cms.hhs.gov	214.767.6478
7	Gail Brown	Gail.Brown@cms.hhs.gov	816.426.6440
8	Trudy Turner	Trudy.Turner@cms.hhs.gov	303.844.7131
9	Beverly Binkier	Beverly.Binkier@cms.hhs.gov	415.774.3580
10	Janice Adams	Janice.Adams@cms.hhs.gov	206.615.2541

For More Information….

- General Questions, Contact Cindy D'Annunzio, 410-786-1878, Cynthia.dannunzio@cms.hhs.gov
- Cycle Questions, Contact the Cycle Managers:
  - 2010 Cycle – Stacey Carroll, 410-786-0241, stacey.carroll@cms.hhs.gov
  - 2011 Cycle – Nicole Perry, 410-786-8786, nicole.perry@cms.hhs.gov
- MEQC Questions, Contact Monetha Dockery, 410-786-0155, monetha.dockery@cms.hhs.gov
- Visit the PERM website at www.cms.gov/perm
- Questions?

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