Medicaid Improper Payment Report

FY 2010

Executive Summary

The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), requires the heads of federal agencies to annually review programs that they administer to:

- Identify programs that may be susceptible to significant improper payments;
- Estimate the amount of improper payments;
- Submit those estimates to Congress; and
- Report on the actions the Agency is taking to reduce the improper payments.[1]

The Centers for Medicare & Medicaid Services (CMS) has identified Medicaid and Children's Health Insurance Program (CHIP) as programs at risk for significant erroneous payments. Like Medicare, these programs expend large sums on behalf of beneficiaries seeking and receiving health care, do business with numerous providers of health care services of many kinds, and receive and process large numbers of transactions involving applications for enrollment (by both beneficiaries and providers), contracts with plans, and claims for reimbursement. The CMS measures Medicaid and CHIP improper payments through the Payment Error Rate Measurement (PERM) program.

The Medicaid three-year weighted average national error rate reported for 2010 is 9.4 percent or $22.5 billion in estimated improper payments, which represents the federal share only. This rate includes improper payment data from 2008, 2009, and 2010. A CHIP error rate was not calculated in 2010.[2] As explained below, however, this rate does not reflect significant changes in measurement methods that were implemented pursuant to recent federal statutory and regulatory changes.

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[1] OMB issued guidance for IPIA implementation requirements through OMB Circular A-123, Appendix C, on August 10, 2006 and has issued subsequent guidance on April 14, 2011.

[2] CHIPRA (P.L. 111-3) required that "Notwithstanding parts 431 and 457 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act), the Secretary shall not calculate or publish any national or State-specific error rate based on the application of the payment error rate measurement (in this section referred to as ''PERM'') requirements to CHIP until after the date that is 6 months after the date on which a new final rule (in this section referred to as the ''new final rule'') promulgated after the date of the enactment of this Act and implementing such requirements in accordance with the requirements of subsection (c) is in effect for all States." In addition, Section 205(c) of the Medicare and Medicaid Extenders Act of 2010 exempts CMS from completing a 2010 CHIP error rate. For these reasons, CMS has not calculated nor included the CHIP payment error rate in this report.

While the federal government, the primary funder of the Medicaid program, has responsibility for interpreting and implementing the federal Medicaid statute and ensuring that federal funds are appropriately spent—including measuring improper payments—the program is administered at the state level with significant state financing. States have both a statutory obligation and a fiscal interest in assuring program integrity. States also have considerable flexibility in designing their programs within federal rules, and are accountable for operating their programs effectively and efficiently. States differ widely in program structure, eligibility, financing, and the level of sophistication and integration of management information systems. The net result is that there is a significant level of state-by-state variation. The measurement of improper payments is therefore correspondingly difficult, and efforts to reduce improper payments require federal and state cooperation.

In addition to differences in state programs, CMS notes that some of our initial methodologies for classifying errors in PERM (particularly with respect to eligibility) drew criticism from states and other stakeholders, resulting in Congressional action to revise our approach for future years. Congress included in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) a provision stating that the payment error rate determined for a state should exclude payment errors resulting from the lack of certain types of verification of an applicant's self-declaration or self-certification of income, and the correct amount of, medical assistance or child health assistance, if the state process for verifying an applicant's self-declaration or self-certification of income was approved by CMS.

On August 11, 2010, CMS published a final PERM regulation allowing a self-declaration statement that is present in the case record to be used to verify eligibility for the PERM reviews if it meets certain requirements, such as not being out-of-date. If it does not meet these requirements, states may obtain a new self-declaration statement or verify the applicant's eligibility using third party sources, such as applicable caseworker notes or information obtained by the PERM reviewer. This provision will conform error rate measurement to federal and state policies concerning eligibility process and required verifications. This revised eligibility review process will first be reflected in the Medicaid 2011 error rate, and future Medicaid and CHIP error rates. Thus, readers should be cautioned when reviewing PERM statistics, particularly for eligibility, that they include some cases previously classified as errors, but which, pursuant to Congressional direction, will not be counted as such in future years.

The final rule includes a number of additional program refinements, many of which are designed to strengthen the validity of the measurement process and to reduce the degree to which the measurement process itself affects payment error rates

Reducing improper payments is a high priority for CMS. We, in collaboration with the states, are working on multiple fronts to address this issue. Through the error rate measurement, CMS identifies and classifies types of errors and shares this information with each state. States then conduct an analysis to determine the root causes for improper payments to effectively identify why the errors occur, which is a necessary precursor to developing and implementing effective corrective actions. The CMS works closely with states following each measurement cycle to

develop state-specific CAPs. States, in close coordination with CMS, are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs. In addition, CMS is continuously reviewing the causes of errors and implementing national and state-focused activities to decrease Medicaid and CHIP improper payments.

Overview

History of Error Rate Production

The CMS tested and refined various methodologies to estimate improper payments in Medicaid and CHIP prior to and after the enactment of IPIA. In 2005, CMS developed the PERM program to review improper payments in three components of Medicaid and CHIP: fee-for-service (FFS) claims, managed care claims, and eligibility cases. The CMS adopted a national contracting strategy to use federal contractors to measure error rates in a subset of states every year. The federal contractors conduct the medical and data processing reviews on claims and collect state claims data and medical policies. The states are responsible for conducting eligibility reviews according to CMS' review guidelines. In 2008, CMS began issuing error rates for Medicaid and CHIP.

The PERM Process

The PERM program uses a 17-state three-year rotation for measuring improper payments in Medicaid, so that CMS measures each state once every three years. The 17 states reviewed each year are a sample of the 51 state Medicaid programs. Each year's cycle national error rate that is calculated projects results from the sample of 17 states to expenditures for the Medicaid program as a whole. The states in each cycle are shown in the table below. In addition, CMS calculates a rolling three-year national error rate, which is the official program error rate. The CHIP measurement follows the same cycle.

Table 1 States in Each 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.

States submit universes of claims data for the FFS and managed care components which are randomly sampled by CMS. For the 2010 report, the sample size was 540 FFS claims for each state. For the Medicaid managed care programs, the sample consisted of 280 claims per year for each state with a Medicaid managed care program. CMS and its contractors collect data for sampled FFS and managed care claims from the states and documentation from providers, evaluate the FFS and managed care sampled claims for payment errors in data processing, and perform a medical record review for FFS claims. If an error was identified during medical review or data processing review, and states disagreed with the finding, states were given the opportunity to request a difference resolution.

At the same time, the states perform the eligibility reviews. States submit the results of their eligibility reviews to CMS and CMS calculates the state and national error rates. CMS expects to recover the federal share of Medicaid payments from the state on a claim-by-claim basis from the overpayments found in error within the sample. CMS also works closely with states to review their error rates, determine root causes of errors and develop corrective actions to address the major causes of errors.

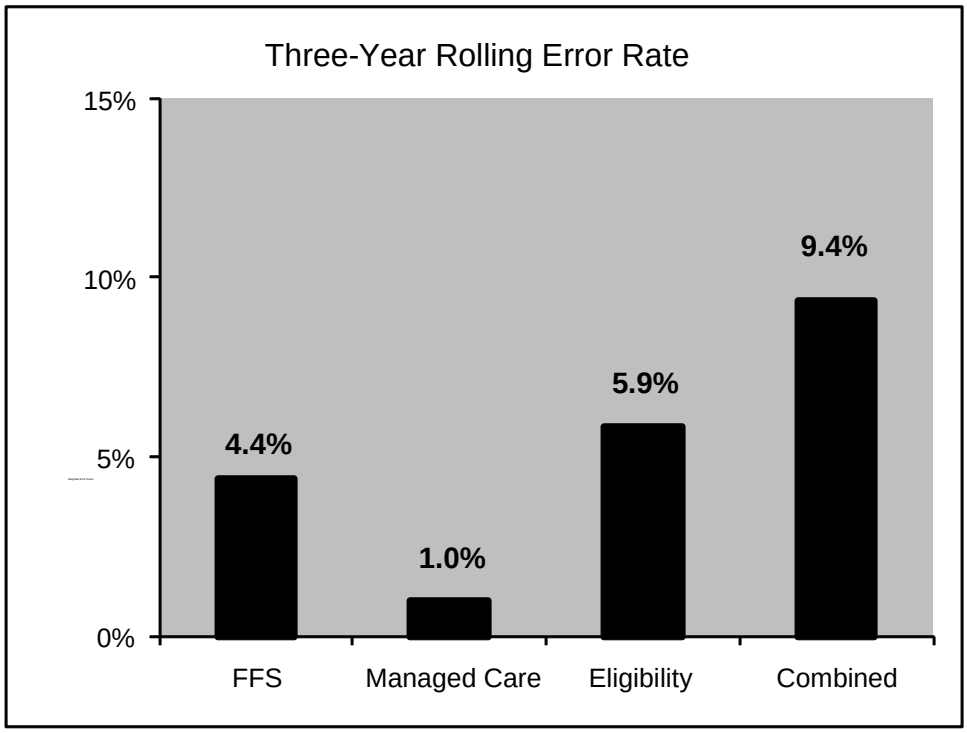
Findings

In 2010, CMS calculated a 3-year rolling national error rate which is a weighted average of the national error rates from the past three years, as well as a projected one-year Medicaid error rate based on the cycle 1 states. The results of those calculations are explained in the following sections.

Three-Year National Rolling Error Rate

2010 is the third year that PERM calculated error rates for all components of the Medicaid program (i.e., FFS, managed care, and eligibility). CMS calculated the 3-year weighted average national error rate that includes data from 2008, 2009, and 2010. This 3-year rolling national error rate is 9.4 percent, or $22.5 billion for the federal share in estimated improper payments. This rate was calculated using the federal share of 2009 Medicaid expenditures totaling $239.0 billion and is the official error rate reported in the 2010 HHS Agency Financial Report. The 3-year rolling national error components rates are as follows: Medicaid FFS: 4.4 percent; Medicaid managed care: 1.0 percent; and Medicaid eligibility: 5.9 percent.

Figure 1 Three-Year Average Payment Error Rates at 90% Confidence Intervals



Note: The national estimate is comprised of the sum of the FFS, managed care, and eligibility components minus a small adjustment to account for the overlap between the claims and eligibility review functions.

As additional PERM cycles are completed, these error rates will be calculated on a rolling basis, where the oldest year will be dropped from the calculation and the newest year added in. The combined national rolling error rate has a margin of error of +/-2.23 percent, which is within the IPIA requirement of +/-2.5 percent.

Table 2 presents the 3-year national Medicaid rolling error rate and the projected dollars in error. Further, the table presents both the upper and the lower 90 percent confidence level percentages

and dollars for each. For the projected dollars paid in error, the table separately shows the total Medicaid and the federal share of the overpayments, underpayments, and total payments.

Table 2 Three-Year National Medicaid Rolling Error Rate

		National Payment Error Rate Estimate	Lower Confidence Limit (90%)	Upper Confidence Limit (90%)
Error Rate		9.4%	7.1%	11.6%
Total	**Total CLAIMS Paid**	**Estimated Dollars in Error**	**Lower Confidence Limit**	**Upper Confidence Limit**
Total Medicaid	$357,984,470,121	$33,650,540,191	$25,416,897,379	$41,526,198,534
Federal Share	$239,012,294,122	$22,467,155,647	$16,969,872,883	$27,725,426,118
Overpayments		**Estimated Dollars in Error**	**Lower Confidence Limit**	**Upper Confidence Limit**
Total Medicaid		$32,270,603,041	$18,988,671,992	$45,552,534,089
Federal Share		$21,499,291,701	$12,292,170,145	$30,706,413,258
Underpayments		**Estimated Dollars in Error**	**Lower Confidence Limit**	**Upper Confidence Limit**
Total Medicaid		$1,379,937,151	($28,205,995)	$2,788,080,296
Federal Share		$967,863,946	$45,787,131	$1,889,940,761

Note - Rounded 3-year rolling payment error rate and confidence interval applied to Total Medicaid and Federal Share amounts without regard to slightly differing 3-year error rates between the overall and Federal Share amounts. The confidence intervals were adjusted accordingly.

Error data from the first three PERM cycles reveal certain findings and trends:

- State Medicaid claims processing systems appear to make most individual payments accurately, with very few data processing errors detected. States also appear to be denying claims properly.
- The eligibility component was the most significant contributor to the overall error rate, especially for the two most recent PERM review cycles. As discussed previously, changes to the way errors are classified in the eligibility process may significantly alter these results in the future. Underpayment errors contribute substantially less to the overall error rate than overpayment errors.
- In the first three years of measurement, most FFS errors discovered during medical review (both dollars in error and number of errors) result from providers failing to submit the necessary documentation to support the claims. For errors reported in 2010, medical

review errors were primarily due to provider billing errors where the provider billed an incorrect diagnosis or diagnosis related group (DRG).

- States make fewer errors processing managed care payments than FFS payments.

Despite the overall consistency to the patterns just described, there are large differences in state-specific payment error rates across states, even within a single PERM cycle. These substantively important differences occur at the component level. CMS attributes the variation across states to multiple factors related to differences in how the states implement and administer their programs. For example, states with proportionately larger managed care programs are likely to have lower overall error rates, since they are processing more monthly payments to plans rather than service level transactions to providers in a FFS environment. Given our past practice of requiring states with simplified or streamlined eligibility processes to collect additional documentation not normally needed by them or provided by beneficiaries, we saw significant variation in eligibility errors based on those state policies as well (again, we expect that this particular source of variation may be reduced in future years based on methodological changes).

It is important to note that while PERM measures payment error rates, the PERM findings should be considered in the context of other policy goals and operational realities. 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, and further refining the PERM methodology to ensure that allowable differences in state policies and administration are not also contributing to differences in error rates.

One-Year Error Rate Based on Cycle 1 States

CMS also calculated a one-year error rate for 2010 based on the sampled cycle 1 states. All cycle 1 states selected for review in this measurement cycle had a Medicaid FFS program, but only 14 had a Medicaid managed care program.

Cycle 1 States	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming

The estimated Medicaid payment error rate based on the cycle 1 states is 9.0 percent, with a confidence interval of +/- 5.28 percentage points at the 90 percent confidence level.

- The total dollar amount projected to be in error estimated from this national error rate is $32.1 billion.
- The federal share of the total dollar amount projected to be in error is $21.6 billion.

It is important to note that many states measured in this cycle have simplified eligibility documentation rules through use of self-declaration and administrative renewal, and were affected by the methodologies we used in the past to require additional documentation for these cases, rather than auditing against the approved state policies and procedures. One state had a 70 percent error rate, partly because of this issue, which significantly impacted the national error rate. We expect that the provision in the PERM final rule (aligning error measurement with permissible federal eligibility policy) will reduce these eligibility-based errors by better aligning PERM methodology with current Medicaid and CHIP policy.

CMS expects to recover the federal share on a claim-by-claim basis from the overpayments found in error within the sample. Within the PERM process, the only funds that can be recovered are from claims that were actually sampled and found to have contained improper payments resulting in overpayments. Therefore, these sampled and reviewed improper overpayments that are subject to recovery are a small fraction of the total amount projected to be in error for the nation for each PERM cycle.

Table 3 presents the one-year Medicaid program payment error rate for 2010 based on the cycle 1 states and the projected dollars in error. Further, the table presents both the upper and the lower 90 percent confidence level percentages and dollars for each. For the projected dollars paid in error, the table separately shows the total Medicaid and the federal share of the overpayments, underpayments, and total payments.

Table 3 2010 Medicaid Program Payment Error Rate and Projected Dollars in Error

	SAMPLE SIZE	NATIONAL PAYMENT ERROR RATE ESTIMATE	LOWER CONFIDENCE LIMIT (90%)	UPPER CONFIDENCE LIMIT (90%)
ERROR RATE	22,297	8.98%	3.70%	14.26%
TOTAL	**TOTAL CLAIMS PAID**	**ESTIMATED DOLLARS IN ERROR**	**LOWER CONFIDENCE LIMIT**	**UPPER CONFIDENCE LIMIT**
TOTAL MEDICAID	$ 357,984,470,121	$ 32,145,819,826	$ 13,243,168,046	$ 51,048,471,606
FEDERAL SHARE	$ 239,012,294,122	$ 21,612,721,749	$ 8,844,760,983	$ 34,380,682,516
OVERPAYMENTS		**ESTIMATED DOLLARS IN ERROR**	**LOWER CONFIDENCE LIMIT**	**UPPER CONFIDENCE LIMIT**
TOTAL MEDICAID		$ 31,440,457,140	$ 12,543,936,162	$ 50,336,978,117
FEDERAL SHARE		$ 21,157,940,224	$ 8,391,732,902	$ 33,924,147,547
UNDERPAYMENTS		**ESTIMATED DOLLARS IN ERROR**	**LOWER CONFIDENCE LIMIT**	**UPPER CONFIDENCE LIMIT**
TOTAL MEDICAID		$ 762,693,028	$ (447,713,955)	$ 1,973,100,011
FEDERAL SHARE		$ 492,121,196	$ (283,842,515)	$ 1,268,084,908

Table 4 presents summary information on the Medicaid results reported in 2010.

Table 4 2010 Medicaid Program Payment Error Rates Based on Cycle 1 States

FY 2010 ERROR RATE	SAMPLE SIZE	NATIONAL PAYMENT ERROR RATE ESTIMATE	LOWER CONFIDENCE LIMIT (90%)	UPPER CONFIDENCE LIMIT (90%)
TOTAL MEDICAID	22,297	8.98%[1]	3.70%	14.26%
MEDICAID FFS	9,295	1.89%	1.27%	2.51%
MEDICAID MANAGED CARE	3,938	0.13%	0.04%	0.21%
MEDICAID ELIGIBILITY	9,064	7.60%	2.26%	12.95%

[1] The national estimate is comprised of the sum of the FFS, managed care, and eligibility components minus a small adjustment to account for the overlap between the claims and eligibility review functions.

Table 5 presents the results for the estimated dollars paid in error by the Medicaid program for 2010. The table shows the total amounts paid and the estimated amounts paid in error. The amounts shown are for overall, overpayments, and underpayments, individually.

Table 5 2010 Medicaid Program Projected Dollars in Error Based on Cycle 1 States

MEDICAID PROGRAM	TOTAL CLAIMS PAID	ESTIMATED DOLLARS IN ERROR[1]
TOTAL MEDICAID	$ 357,984,470,121	$ 32,145,819,826
MEDICAID FFS	$ 276,561,722,435	$ 5,223,579,808
MEDICAID MANAGED CARE	$ 81,422,747,686	$ 102,874,755
MEDICAID ELIGIBILITY	$ 357,984,470,121	$ 27,224,437,952
	ESTIMATED OVERPAYMENT DOLLARS IN ERROR[1]	**ESTIMATED UNDERPAYMENT DOLLARS IN ERROR[1]**
TOTAL MEDICAID	$ 31,440,457,140	$ 762,693,028
MEDICAID FFS	$ 4,471,623,114	$ 751,956,694
MEDICAID MANAGED CARE	$ 102,419,231	$ 455,523
MEDICAID ELIGIBILITY	$ 27,214,135,487	$ 10,302,464

[1]The total dollars in error is comprised of the sum of the FFS, managed care, and eligibility dollars in error minus a small adjustment to account for the overlap between the claims and eligibility review functions.

Reducing Improper Payments

CMS structured the PERM methodology to produce an unbiased estimate of the error rate through review of a relatively small, random sample of claims. States' systems, claims payment methodologies, eligibility determination processes, and provider compliance with record requests and billing errors have contributed to the national error rates. The PERM process identifies and classifies types of errors, but states must conduct root cause analysis to identify why the errors occur, which is a necessary precursor to effective corrective action. Thus, states are critical partners in the corrective action phase of the PERM cycle. Both CMS and state activities to decrease improper payments are discussed in the following pages.

State Corrective Actions

CMS works closely with states in each measurement cycle to develop state-specific corrective action plans (CAPs). States, in coordination with CMS, are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs.

States submit to CMS their CAPs following the publication of the error rate report. The CAPs include the following:

- Data analysis – an analysis of the findings to identify the reasons for errors and where errors are occurring

- Program analysis – an analysis of the findings to determine the root causes of error in program operations
- Corrective action planning – steps taken to determine cost-effective actions that can be implemented for achieving error reduction
- Implementation – plans to operationalize the corrective actions, including milestones and a timeframe for achieving error reduction
- Monitoring and evaluation – to assess whether the corrective actions are in place and are effective at reducing or eliminating the targeted root causes of the errors

Cycle 1 states developed CAPs based on their first PERM measurement. Because much of the error rate that year was due to missing or insufficient documentation, the majority of states focused on provider education and communication methods to improve the responsiveness and timeliness of submission of requested documentation. These methods included provider training sessions; meetings with provider associations; notices, bulletins and provider alerts; provider surveys; improvements and clarifications to written state policies emphasizing documentation requirements; and performing more provider audits. We believe these methods proved successful as documentation errors accounted for approximately 60% of errors identified in the first PERM measurement of cycle 1 states, but only 40% in the PERM measurement of cycle 1 states.

The results of the 2010 reporting period highlighted errors in eligibility – again to be viewed with some caution in light of the changes Congress and CMS have made to our measurement approach. Nonetheless we see some important findings and states are taking action to address vulnerabilities. The three main sources of eligibility errors were: 1) undetermined findings due to states' inability to secure beneficiary information, 2) ineligible beneficiaries, and 3) eligible beneficiaries for whom ineligible services were billed. Specific corrective action strategies implemented by many states to reduce eligibility errors have included better leveraging technology and available databases to obtain eligibility verification information without client contact; providing additional caseworker training, particularly in areas determined through PERM review to be error-prone (e.g., earned income, duplicate benefits); and providing additional eligibility policy resources through a consolidated manual and web-based training. In addition, some states are using administrative renewals in an effort to streamline processes and obtain valid documentation without contacting the beneficiary. Moreover, the investments being made by the federal government and states to streamline, standardize and simplify eligibility processes, and to modernize technology solutions (including real-time verifications) in support of those activities, have the potential to greatly improve the integrity of the Medicaid and CHIP programs.

The same states reviewed in the 2010 report will be reviewed and reported again in 2013. The re-measurement audit will document effectiveness of prior years' corrective actions and we expect to see improvement in payment error rates.

CMS Program Improvements

CMS has also made significant efforts to decrease improper payments. In the first two PERM cycles, most FFS medical review errors resulted from providers failing to submit the necessary documentation to support the claims. It is possible that some or even all of these claims were accurate, but CMS and its contractors could not verify their validity in the absence of sufficient documentation. In response, CMS increased efforts to reach out to providers and to obtain medical records for reviews. This activity had a significant impact on reducing the no documentation errors in 2010. In addition, most cycle 1 states—with knowledge of the impact these errors had on the error rates—put significant effort into educating providers, tracking medical record submission progress, and assisting in collecting records. Further, in 2009, CMS advanced a pilot program to provide states more information on the potential impact of these documentation-category errors and more time for the states to work with providers to resolve them. These combined efforts substantially reduced the number of no documentation and insufficient documentation errors. Lastly, CMS sponsored a series of provider open forum calls from May 2010 through August 2010 to educate providers on what they are required to do if they receive a request for documentation. CMS also enhanced the CMS PERM website with up-to-date information regarding the PERM program; established a separate web page for providers with relevant educational materials developed for providers; supported states' provider education efforts; and established a group e-mail account for providers to communicate directly with CMS.

CMS is also developing ways to reduce the state burden and align PERM data collection more closely with other CMS program integrity data collection processes. Over the past two years, CMS developed and pilot tested a new, streamlined methodology (referred to as "PERM Plus") to collect data required for PERM. The new methodology transfers much of the PERM data collection burden to PERM contractors where CMS holds the contractor, not the state, responsible for taking "raw" claims data and developing a universe for sampling that complies with the PERM instructions. When implemented, this approach would position CMS to integrate PERM data collection with other emerging CMS program integrity initiatives, thus easing the administrative burden on states.

Additionally, CMS is continuing to improve and modernize its data systems and processes. Through the Medicaid and CHIP Business Information Solutions (MACBIS) Council, CMS has put in place a governance structure to oversee the introduction of significant efficiencies and quality improvement activities into our data management. Through improved planning practices, CMS will reduce the requests of states to provide data without compromising the ability to generate valuable performance information.

CMS bases the PERM error rates on reviews of a sample of individual service-level FFS and managed care payments made in the fiscal year under review. However, the PERM sampling and review methodology is designed around individual service-level claims. States have struggled with including payments that are not made at a beneficiary level (such as some transportation and dental claims) referred to as "aggregate payments." States have expressed concern and confusion regarding the inclusion of these payments in the PERM universe, including both the level of effort required to generate and submit payment records, as well as the

overall validity of the review. In response to these concerns, CMS developed a theoretical framework to incorporate these payments into the PERM review, and pilot tested the approach with three states. Based on the success of the pilot, the aggregate payment framework will be applied to all states in the next cycle. The framework includes specific decision points to determine not only if and whether the state should submit beneficiary-level records or aggregate payments. States that submit aggregate payments will submit them at the lowest level for which a payment entry is available electronically. The aggregate payments will be incorporated into the existing stratification approach. The review process will vary according to state-specific program documentation requirements.

CMS is continuing to review Medicaid Eligibility Quality Control (MEQC), a statutorily-required program requiring states to annually provide an estimate of improper payments in Medicaid based on eligibility reviews, and PERM program requirements to reduce redundancies between the two measurements. Harmonizing the two programs could reduce duplication and improve consistency in eligibility reviews and provide meaningful results for corrective actions. CMS is also examining how to ensure that PERM review processes are in line with the Medicaid eligibility determination changes enacted in the Affordable Care Act.

Due to the complexity of the Medicaid and CHIP programs and variations in state systems' sophistication, there are a variety of program structures, program management, and payment processes which make it difficult for states to comply with PERM, and result in late, inaccurate, or incomplete data. CMS has undertaken a variety of actions to mitigate these program vulnerabilities. CMS has updated and refined the PERM instructions to clarify the universe requirements, and established a variety of "pre-cycle" activities to assist states in understanding and applying the PERM data rules. CMS also conducts site visits to states prior to the first data submission.

As an additional program corrective action, CMS formed a state systems workgroup to address individual state systems problems that may cause payment errors. The workgroup includes representatives from the CMS central office and regional office staff and the appropriate state staff.

Lastly, the recent PERM final rule includes a number of additional program refinements, many of which are designed to strengthen the validity of the measurement process and to reduce the degree to which the measurement process itself affects payment error rates. In addition to the acceptance of beneficiary self-declared information for purposes of validating income, the final rule allows improvements to the PERM processes such as the following:

- Extends provider response time to submit records for PERM from 60 days to 75 days;
- Extends states' timeframes for requesting difference resolutions from 10 business days to 20 business days and timeframes for requesting appeals from CMS from 5 business days to 10 business days;
- Eliminates dollar thresholds for error amounts and allows states to file a CMS appeal on any error;

- Individualizes sample sizes (for each state) for future measurements based on state error rates from previous cycles; and
- Increases corrective action plan (CAP) development timeframes for states from 60 days to 90 days.