Payment Error Rate Measurement (PERM)
Corrective Action Summary

A. State: XXXXXXX **Fiscal Year:** 2010

B. Date: 2/15/2012

C. State Contact: XXXXXXXXXX
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. SCHIP (now referred to as 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: XXXXXXX **Fiscal Year:** 2010

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 though 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:** 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: XXXXXXX **Fiscal Year:** 2010

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.

3. 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.

4. 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.

5. **<u>Implementation:</u>** 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.

HHSC 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.

Payment Error Rate Measurement (PERM)
Detailed Corrective Action Plan

A. **State:** XXXXXXX **Fiscal Year:** 2010

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.

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

Action		Date Implemented	Expiration Date
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 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.	

5. **<u>Evaluation:</u>** 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.

Payment Error Rate Measurement (PERM)
Detailed Corrective Action Plan

A. State: XXXXXX Fiscal Year: 2010

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

Action	Date Implemented	Expiration Date
Medicaid Program Representatives will	04/2010	

provide training as needed		
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	

Payment Error Rate Measurement (PERM)
Detailed Corrective Action Plan

A. State: XXXXXX Fiscal Year: 2010

B. State Contact: XXXXXXXXXX
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

Action	Date Implemented	Expiration Date
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
Simplify and clarify identified policy that is complex as needed	07/2010	

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

A. State XXXXXXX Fiscal Year: 2010

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%.

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

A. **State:** XXXXXXX **Fiscal Year:** 2010

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:**

Action		Anticipated Implementation Date	Actual Date Implemented
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

Action		Anticipated Implementation Date	Actual Date Implemented
	Medicaid Expansion (each LDSS)	May 2010 June 2010	July 2010 August 2010
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	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.