# 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)

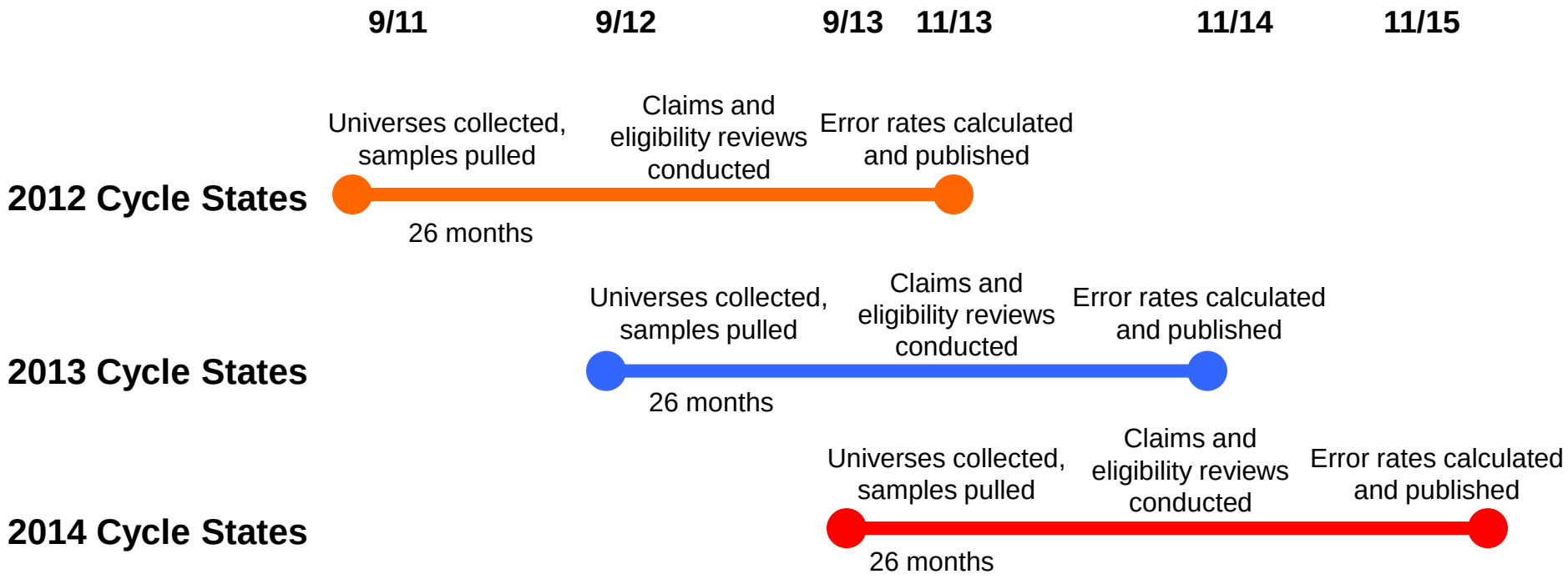
# PERM State Rotation

| 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

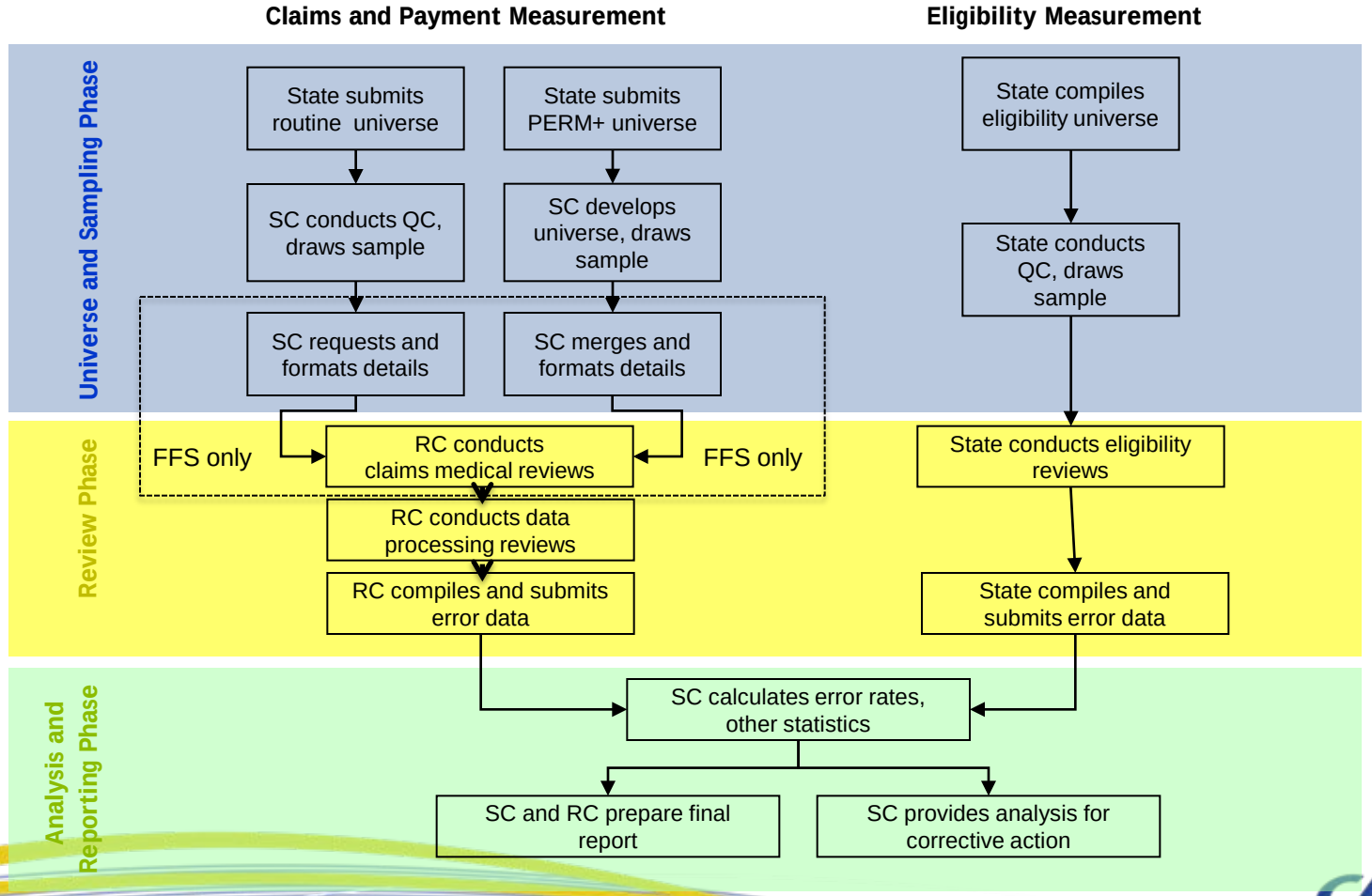
# Statistical Contractor Responsibilities

- 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

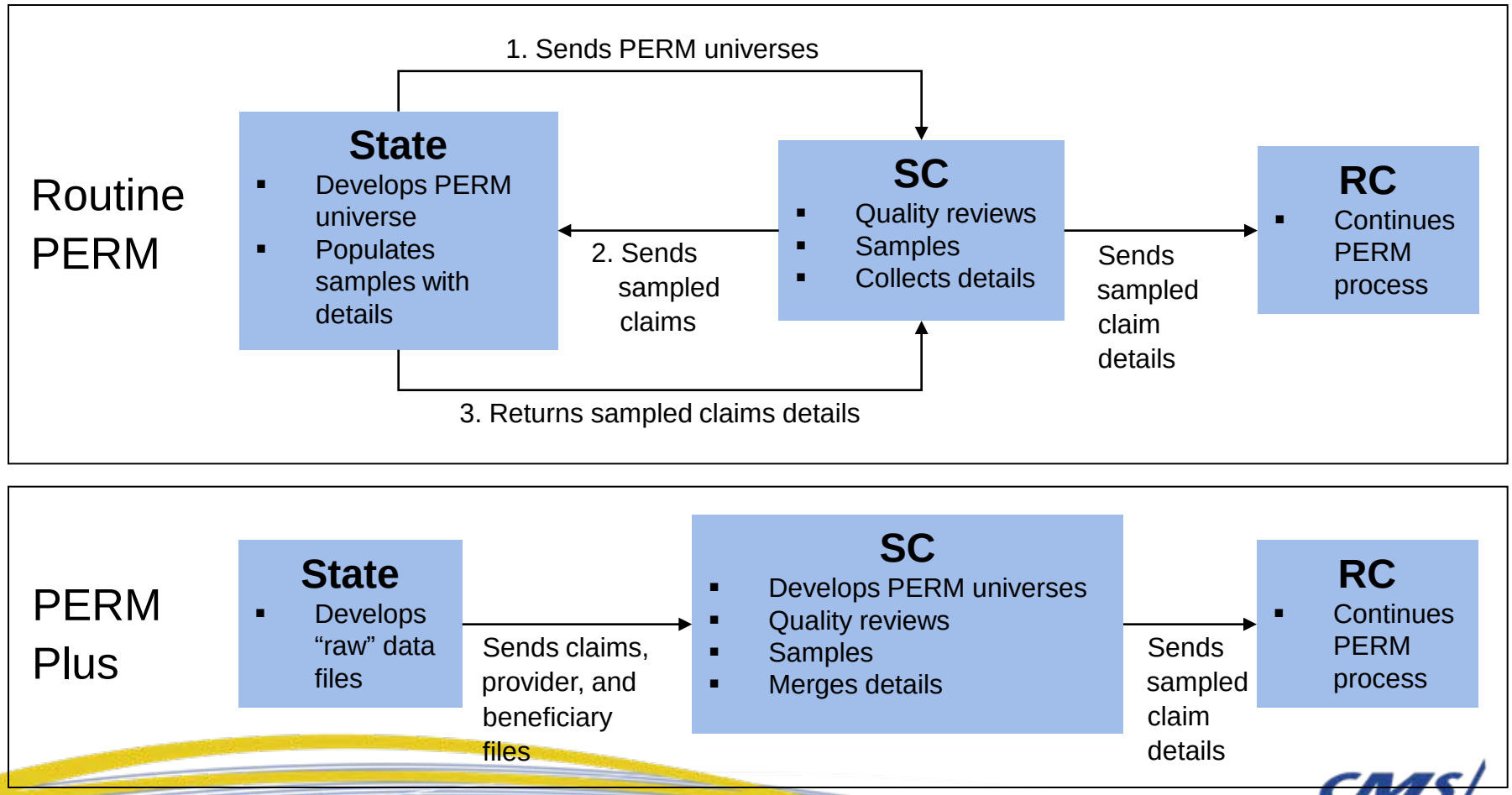
# Statistical Contractor: Universe Collection

- 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
- 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**

Stacey Carroll

410-786-0241

Stacey.carroll@cms.hhs.gov

Central PERM eligibility email: PERMeligibility2012@cms.hhs.gov

Central PERM email for providers: PERMProviders@cms.hhs.gov

Eligibility Lead: Jessica Woodard 410-786-9249 jessica.woodard@cms.hhs.gov

Recoveries Lead: Felicia Lane 410-786-5787 felicia.lane@cms.hhs.gov

Division of Error Rate Measurement Director: Cindy D'Annunzio 410-786-1878 cynthia.dannunzio@cms.hhs.gov

# Statistical Contractor Contact Information

The Lewin Group
PERM Statistical Contractor
3130 Fairview Park Drive
Falls Church, VA 22042
703-269-5500

All PERM correspondence should be directed to our central PERM inbox:

permsc.2012@lewin.com

Moira Forbes
Project Director
moira.forbes@lewin.com
703-269-5631

# Review Contractor Contact Information

A Plus Government Solutions
PERM Review Contractor
1300 Piccard Drive, Suite 205
Rockville, Maryland 20850
301-987-1100

Linda Clark-Helms
Project Director
lclarkhelms@aplusgov.com
410-221-9990

Sharon Kocher
Project Manager/DP Manager
skocher@aplusgov.com
602-460-7424

Bradley Allen
Medical Records Manager
ballen@aplusgov.com
301-987-1101

Fax line for record submission
877-619-7850
Provider calls
301-987-1100