Payment Error Rate Measurement (PERM)

Policy Issues

September 2007

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GENERAL ISSUES

Q1. If States should not be referencing the instructions for the 2006 and 2007 States, when can they expect to receive more firm guidance on planning for 2008 and beyond? For example, when are the eligibility sampling plans due? States are concerned that the FFY is quickly approaching.

A1. States can use the existing instructions for planning purposes, but should be aware that, as the program matures, CMS may make revisions to these instructions that are intended to reduce cost/burden and/or make the process more efficient or otherwise improve the error rate measurement process.

In terms of timeframes for eligibility, the statistical contractor for PERM will be contacting the FY 2008 States for sampling plans which are due to the statistical contractor by August 1, 2007.

With regards to fee-for-service and managed care reviews, FY 2008 States will participate in a kick-off call with CMS and the PERM contractors. Shortly thereafter, they will be invited to participate in teleconferences with each of the contractors, i.e., the statistical contractor, the documentation/database contractor, and the review contractor. After the group calls, each State may receive individual phone calls from the statistical contractor and the documentation/database contractor. Subsequent to these phone calls, each State will receive a comprehensive package from the statistical contractor that instructs them on submitting claims data for the FY 2008 PERM cycle.

Please note that we expect to hold the first FY 2008 PERM cycle call in September 2007.

Q2. As CMS tweaks the PERM measurement process each year, they reduce the possibility that PERM will actually be able to be used to evaluate a State's progress over the years, since the methods will be different.

A2. We intend to work with the States to improve the measurement process as the program matures. States have also asked for more input in this process. However, we believe the basic measurement will remain the same. Improvements should affect such areas as cost, burden, and inefficiencies, but should not affect the ability to track State progress over time.

Q3. The Medicaid Integrity Group (MIG) has mentioned that it will be conducting audits using a 17 State rotation methodology, similar to the Payment Error Rate Measurement (PERM) program. Can the Office of Financial Management (OFM) and MIG work together to make sure that States are not being audited by MIG and measured for PERM in the same calendar year?

A3. We will take this suggestion under consideration for FY 2008 or FY 2009.

Q4. Will the Statistical Contractor (SC) recompete affect requirements for the FY 2006 and FY 2007 measurements? Do States send their eligibility sampling plans to The Lewin Group or to CMS? What assurances can CMS give the States that the recompete will not impact measurement operations?

A4. The SC recompete will apply only to the FY 2008 PERM cycle. The Lewin Group remains the incumbent SC for both the FY 2006 and FY 2007 measurement cycles. States send their eligibility sampling plans directly to The Lewin Group. Since there will be no change in Statistical Contractor during any given PERM cycle, CMS is confident that the recompete will not impact measurement operations.

Q5. Will CMS reconsider the idea of making the FY 2006 and FY 2007 measurements a pilot program? Is there anything by law prohibiting CMS from doing this? The States feel that the measurements are in so much flux that a true measurement will not occur until FY 2008 or FY 2009.

A5. After careful consideration, CMS is unable to treat the FY 2006 and 2007 measurements as pilots. CMS has worked closely with the Office of Management and Budget (OMB) to develop the PERM program and the timeline for its implementation in order to be in compliance with the Improper Payments Information Act of 2002 (IPIA) requirements. In the October 5, 2005 Interim Final Rule and the August 28, 2006 Second Interim Final Rule, CMS announced its strategy to measure improper payments for purposes of complying with the IPIA.

Q6. Can CMS mention in the Performance and Accountability Report (PAR) that the program policies and operations are still dynamic and that the program is still in its infancy, and that this should be considered when reviewing the findings for FY 2006 and FY 2007?

A6. CMS acknowledges that the FY 2006 PERM measurement is the first error rate report in full program implementation. As such, CMS will indicate this in its internal report to the Department of Health and Human Services and OMB.

Q7. Will CMS provide a summary of the major changes made in the final rule on its web site?

A7. CMS has posted the final rule to the PERM website for review. This can be found at www.cms.hhs.gov/PERM . The regulation can also be found published in the Federal Register (FR, Vol. 72, No 169, Friday, August 31, 2007). Please refer to page 50511, section IV. Provisions of this Final Regulation for a summary of changes made in the final rule.

Q8. Will the Office of Inspector General (OIG) reviews of the States add another layer to the PERM operational process for the States? How many more reviews will there be and where will future reviews take place?

A8. No, the OIG is not adding another layer to the PERM operational process for States. The OIG/Office of Audit is an independent government audit organization. They have oversight responsibility to ensure that the PERM process is adequately implemented and can produce a valid error rate in accordance with applicable criteria. The OIG does not establish the PERM operational process for CMS or the States. CMS establishes and implements the process.

As part of the OIG oversight responsibility, the PERM review process will be reviewed each year and the OIG will visit several States each year. The OIG has not yet selected the States that they will be reviewing in the coming years.

Q9. Did lessons learned from the Payment Accuracy Measurement (PAM) pilot get incorporated into the final rule? A review process regarding pharmacy claims was used in the PAM pilots (which was considered a best practice) but was not incorporated into PERM reviews? Can CMS explain?

A9. The PAM pilot studies were designed to develop and test methodologies for measuring the accuracy rate of Medicaid payments and to measure the source and amount of improper Medicaid payments. Lessons learned from the PAM pilots were incorporated into the PERM final rule.

In the PAM pilot, the States did their own medical record reviews, including pharmacy claims. In the PERM process, all reviews are done by the Review Contractor. The Review Contractor obtains State policies regarding medical records, and conducts the reviews in accordance with the specific State regulations for the medical record under review. There may be State policies or practices that do not conform to Federal regulations or policies, in which case Federal regulation would take precedence

Q10. If CMS reconsiders making changes in regards to MR2 errors and the 60 day deadline for claims adjustment, when will these changes be made effective? What due process will be given to States whose measurement / error findings are complete and what impact will this have on the FY 2006 and FY 2007 measurement?

A10. Please refer to the final rule for information on when MR2 errors can be considered in the difference resolution process effective October 1, 2007. CMS is currently researching issues related to the second question.

Q11. When are the instructions for FY 2008 going out to the States?

A11. CMS recently released a State Health Official letter to the FY 2008 States containing basic instructions about the PERM process as well as inviting the States to a kickoff conference call with CMS and the contractors to introduce the PERM program. Current instructions regarding eligibility and the difference resolution process can be found on the PERM website.

FEE-FOR-SERVICE AND MANAGED CARE CLAIMS SUBMISSION

Q1. Will the 2008 States be stratifying the claims?

A1. CMS has found that States have had difficulty complying with the requirement to stratify the fee-for-service claims. Therefore, we expect that the FY 2008 States will not be stratifying these claims. However, the measurement for FY 2008 and beyond most likely will operate under the provisions of a final regulation, which has not yet been published. Managed care claims are not stratified.

Q2. In the required fields for the managed care universe data submission, what is meant by the "managed care program indicator"? Is this the benefit category (SOBRA, Acute, LTC, etc.) that the recipient was approved for?

A2. Yes. In many States, managed care rates are based on sex, age, geographical location and program type. The managed care program indicator should reflect any categorization by program that a State uses to determine payment rates.

Q3. If the universe is due on the 16th of the month following the end of the quarter and the sample data is due by the 15th of the following month, who will forward the sample to the State? If the State must provide the sample detail within two weeks of receiving the sample, the timeframe seems a little tight to collect all the information regarding adjustments and submit it so that the documentation/database contractor receives it within the two weeks. Will the timeline be rigidly adhered to?

A3. In the FY 2006 PERM cycle, the statistical contactor contacts the States to acquire the sample detail, which also includes provider information and claims adjustments. However, beginning with the FY 2007 States, the documentation/database contractor will be contacting the States to acquire the sample detail, again including provider information and claims adjustments. Since this process takes place on a flow basis, we believe that our timeline is feasible.

Q4. Can physician orders be both written and oral for pharmacy claims? Is one valid or invalid? What instructions have been given to the PERM contractors on how to handle these claims?

A4. Both verbal and written physician ordered prescriptions are being reviewed. They are both valid. In both cases they are being looked at in terms of State pharmacy regulations and Medicaid guidelines.

ELIGIBILITY

Definitions

Q1: For the purpose of PERM eligibility, how is a case defined?

A1: For the purpose of PERM, a "case" is defined as an individual beneficiary, not a family or household unit. (Please note that if your data systems are at the family or unit level, rather than the beneficiary, there are ways to minimize the burden of sampling at the beneficiary level. Please contact The Lewin Group for any further guidance you may need.)

Q2: If a State has a joint application for Medicaid and SCHIP and a case is denied for both programs, does it fall in the Medicaid negative universe or the SCHIP negative universe?

A2: The case would be placed in the negative universe of both the Medicaid and SCHIP programs and, if sampled, would be reviewed under both programs to determine that the denial for each program is correct.

In States with a joint application, the application is considered an application for each program. Therefore, applications that are approved for SCHIP should be placed in the negative universe for Medicaid in the sample month as well as in the active case universe for SCHIP because the case was denied for Medicaid. If a joint application is approved for Medicaid and denied for SCHIP, the case would be placed in the Medicaid active universe and the SCHIP negative universe.

Q3: How does PERM define a "completed application" and a "completed redetermination"?

A3: A "completed application" and a "completed redetermination" are defined as an application or redetermination where the beneficiary met all Medicaid and/or SCHIP requirements to complete the process (e.g., provided necessary financial and categorical information and signed appropriate forms).

An incomplete application and redetermination occurs when the beneficiary does not take the necessary action that would allow the State Agency to determine eligibility (e.g., the beneficiary completes a written application but does not provide documentation of eligibility or the beneficiary does not keep an appointment to complete an eligibility redetermination).

Q4. The PERM eligibility sampling guidelines define a redetermination as follows: "A case constitutes a redetermination for the sampling month if the State took an action to continue eligibility in the sample month based on a completed redetermination." This could mean that the State conducted the mandated 6 or 12 month complete review. This is a review that requires the applicant to update all data collected at first application, and the eligibility worker reviews all of these data in making a decision

about continued eligibility. Alternatively, this could mean that the State took an eligibility action during the sample month based on some single new piece of information that happened to come to the State's attention. For example, if an enrollee reported a change in income, the State would review the case to see if that single change required a change in eligibility. Does the PERM redetermination category include both of these kinds of "redeterminations?"

A4: Yes. A redetermination is not restricted to the minimal annual requirement. A redetermination occurs any time the State took an action to redetermine eligibility

Q5: If a client is redetermined for a different Medicaid category (i.e., was covered under Section 1931 and goes to transitional Medicaid under Section 1925 of the Social Security Act) what strata should this case be in? Should they go in stratum 3 because they are continuously on Medicaid even though it is a different eligibility type? Our system would not see this as a redetermination. A redetermination is the annual redetermination that occurs when a client sends back in their redetermination packet, effectively re-applying for benefits. This is simply a client reporting a change that affected what program they were on but not their eligibility.

A5: You should consider a move from one coverage category to another category as a redetermination and place the case in stratum 2. The reason is because the beneficiary provided information that could affect eligibility and therefore, a State would redetermine his/her status.

Q6: Can we use our definition of new recipient? Our definition of a "new recipient" is one who never participated or had a break in coverage of more than three months. A reopening within a three month lapse in coverage is considered a re-determination (continuation) of eligibility.

A6: CMS would expect a new application when there has been a break in coverage for a significant amount of time in both Medicaid and SCHIP. Therefore, the PERM eligibility process will follow CMS policy to consider cases with breaks in coverage as applications. These cases should be placed in stratum one.

Q7: When defining a case for the negative universe, does the same definition apply for the active universe? The denials and terminations in our system are keyed based on the household or family unit and not on individuals. For the negative universe will it be necessary to disaggregate the household into individuals or will States be allowed to show the family unit as a case for the universe?

A7: Because the negative case error rate is not dollar-weighted, the definition of a case as a single beneficiary is not as significant in the negative universe as it is in the active universe, particularly if an entire family unit is being denied or terminated for the same reason. However, for consistency, the State should sample for the negative universe at PERM-defined case level. States that make denial and termination decisions at the household/family unit level should draw a random sample at the household/family unit

level. Once the sample is drawn, the State should randomly sample one individual from the household/family unit level to use as the single beneficiary for the case.

Q8: This question pertains to cases that should be included in or perhaps excluded from the negative universe for either Medicaid or SCHIP. The PERM Verifying Eligibility for Medicaid and SCHIP Benefits, Version 09/28/06, refers to a negative case as one that "contains information on a beneficiary who completed an application for benefits and the State denied the application for benefits or who completed the redetermination process but whose program benefits were terminated by the State."

Would the following types of actions be included in the negative universe? (These actions could take place any time, not just at redetermination.)

- **Recipient requested that benefits be terminated**
- **Reason for termination is due to the fact that the recipient was approved in another case**
- **Unable to locate the recipient**
- **Recipient moved out of state**
- **Recipient is deceased**

A8: We defined applications, redeterminations, denials and terminations in the manner that we did because the eligibility workgroup recommended that PERM measure only those cases where the State took an action based on complete participation by the beneficiary. Therefore, any case that was denied or terminated because the beneficiary did not cooperate in establishing his/her eligibility would be excluded from the negative case universe.

Sampling Plan

Q9: Is the Lewin Group available for assistance with the sampling plans?

A9: Yes. The Lewin Group is available for assistance and to speak one-on-one with the States. Please send an email to permsc.2007@lewin.com to arrange a meeting.

Q10: When is the eligibility sampling plan due to The Lewin Group?

A10: The FY 2006 plan was due to The Lewin Group (CMS' statistical contractor) on November 15, 2006. Lewin will review the plan and work with the States to meet the needed requirements in order to have an acceptable sampling plan by January 15, 2007. For FY 2007 and beyond, the sampling plan is due 60 days prior to the fiscal year being measured, i.e., August 1.

Q11: Where should States send the sampling plan?

A11: Sampling plans should be emailed to The Lewin Group by August 1 prior to the fiscal year being measured. The address for eligibility sampling plan submission is: permsc.2007@lewin.com.

Please include in the subject line the name of the State, program (Medicaid or SCHIP), and the phrase "Eligibility Plan Submission." Also include in the email the name and email addresses of the person or persons who should be contacted if we have questions or concerns about the sampling plan. Lewin will track and report the receipt of sampling plans to CMS.

Q12. What information do you need to approve a sampling plan? Do you need the program codes, what cases are assigned to that program code, and what universe they will be sorted into?

A12: We do not need program codes, except to the extent that it is the most economical way to describe the universe. All information regarding what is needed in the sampling plan is included in the eligibility guidelines and in the eligibility sampling plan request letter.

Q13. What should States do if they cannot complete the sampling plan (or portions of it) due to outstanding policy questions?

A13: The State should submit the sampling plan, as complete as possible, to The Lewin Group by August 1. If there is an issue that cannot be addressed in the sampling plan because the State is waiting for additional policy clarification, please note the issue (and any proposed alternative the State may have developed) so that Lewin can follow up as part of the review and approval process.

Sampling Methodology

Q14: Why was the design made to use a two tail test confidence level parameter (1.96) instead of a one tail parameter (1.64) since the expected eligibility values are only "correct" or "in error" and not a range with values on both sides of correct, the expected mode (average for nominal data)?

A14: A confidence interval is calculated around an error rate. In the case of active cases that are dollar-weighted, this error rate will be the ratio of dollars in error to total dollars paid. It will be a percentage (e.g., a rate of 2%). The confidence interval will be calculated around this point estimate. It will be the equivalent of a two-tailed test. Similarly, for the non-dollar weighted error rate (the case is either correct or incorrect) the error rate is the percentage of cases in error, and the confidence interval is around this point estimate. The actual precision requirements (+/- 3 percentage points with 95% confidence) were chosen to be able to determine the true error rate with a precision level that is sufficient for corrective actions. The sample sizes are about the same as those required to meet the national precision requirements for an error rate, specified in the Office of Management and Budget's implementing instruction as +/- 2.5 percentage points with 90% confidence.

Q15: Is it required that our SCHIP program sample 504 active cases and 204 denials? We do not understand why our sample size would be the same size as the Medicaid program's sample size, especially when you consider the difference in population sizes for each program. Our Medicaid program has 373,000+ individuals per year, while SCHIP has around 37-38,000.

A15: A property of sampling is that, once the population size exceeds about 10,000, the population can be treated as if it were an infinite population. All else remaining the same, the sample size necessary to a achieve a given precision level when the population is about 10,000 is about the same as the sample size necessary to achieve the same level of precision when the population is 10 million or 10 billion.

The only exception to the sampling numbers provided in the guidelines is a finite population correction factor which can be used only if a program's total population from which the full year sample is drawn is less than 10,000. In the case of the SCHIP program described above, the standard sample size calculation would apply. While it may seem strange to compare the size of Medicaid to the size of SCHIP, statistically speaking, beyond a universe of about 10,000, population differences do not have a significant effect on sample size.

The sample size chosen is estimated to obtain a precision level of 3 percentage points at the 95 percent confidence level, assuming an eligibility error rate of 5%. By the nature of sampling, there are no absolute certainties, but a sample size of 504 is likely to achieve the precision goal with a high probability. The 5% error rate for the sample size calculation was determined by an eligibility working group. The sample size is based on a prudent judgment, and takes into account the variance due to a 5% error rate and the additional variance due to the dollar value of the claims that will be associated with the active case error rate. That is, some cases sampled may have a large dollar volume of claims associated with them and some may have a small dollar volume or even no claims. This source of variation contributes to the overall variance of the estimated error rate. In future years, states may use their actual error rate from the most recently completed year to calculate the sample size. However, for a State's first year in PERM, the assumed error rate, and therefore the sample size, is standard across all States.

Q16: For what reasons should States drop cases from a random sample?

A16: Under PERM, the only instance where a case can be dropped and replaced is if the case is found to be under active beneficiary fraud investigation. The State can over-sample for a given sample month to replace beneficiary fraud cases.

One other reason that a case may be dropped and replaced is if the case should not have been included in the universe in the first place. For example, if a Title IV-E foster care case was erroneously included in the universe and sampled, it may be replaced by an over-sampled case. However, these instances should be rare, and the State should conduct quality assurance of the universe to minimize these instances.

States should obtain sampling approval from the Lewin Group prior to submitting a new sample plan or replacing dropped cases with new cases.

Q17: Our plan is to do our random sampling by taking the total number in a universe and dividing it by the sample size we need. Then, we will select the member that is equal to that answer. For example, if we have 100 people in the SCHIP active application in the month of January and we need 20 cases, every 5th member will be identified.

A17: Your sampling method is acceptable but in order for the sample to be random, if you were going to take every 5th case for instance, you would first need to pick a random number between one and five and start from there. Starting from the first case and taking every 5th case would not provide a random sample (e.g. you would use SAS or some other statistical program to choose a random number between one and five. If the number were 2, the first case you would use would be the 2nd case, then the 7th, etc.). You will need to describe the specifics of your random sampling method in your sampling plan.

In addition, if you are going to over-sample for active beneficiary fraud using the skip method, you will also need to explain in your plan how you will identify the cases that will be set aside as the over-sample (i.e. if you are going to over-sample stratum one in January by two cases using the skip method, you would need to draw a sample of 20 cases and then randomly select two of those cases as your over-sample).

Q18: Where does the 5% assumed error rate come from?

A18: The 5% error was estimated by the eligibility work group convened by CMS. This rate was chosen in order to achieve the most accurate payment error rate possible and because there is no reliable information on Medicaid and SCHIP error rates. After a State's initial year in PERM, its actual error rate can be used to determine the sample size for the next measurement year.

Q19: Could a State start the selection and review process beginning October 2006 instead of more sampled cases per month for the period January – September 2007? By starting in October, our PERM process will be more closely aligned with our MEQC process, facilitate its management, and lessen the burden of operating both requirements concurrently.

A19: CMS established the first quarter for FY 2007 as an implementation timeframe for all FY 2007 States. Since this is the first year of the eligibility measurement, CMS would prefer a consistent approach to sampling by all States.

Q20. How can an error rate be determined from case-based eligibility reviews if there are no paid claims for the case being reviewed? Can CMS provide its justification for why States should invest time and resources reviewing a case where no Medicaid or SCHIP payments have been expended?

A20. The sample drawn for eligibility reviews is random. States would not know until the claims collection process, which begins after the review is done, whether there were claims paid on a case. The error rate is determined from the payments on all cases in the sample, which would include zero paid claims.

Q21. If the reason for the case-based sample is that the reviews are more current, how current are they? The sample claims draw is for a 3 month period immediately preceding the month the sample is actually drawn. In order to get a valid sample for the eligibility reviews of 702 cases, we have to draw from a universe of recipients with paid claims as the first criteria. How can an accurate payment error rate measurement be drawn from two different sample universes, one where there may not be paid claims for some of the sample cases?

A21. The eligibility review can be as current as the same month the case is sampled. The sample for eligibility reviews is drawn each month. The sample is valid because it is a random monthly sample of all cases in the universe for that month. There are not two different sample universes.

Q22. If a State uses the sample sizes that CMS has published for eligibility review, will CMS deem that the results will meet the confidence levels required?

A22. The sample sizes were estimated to achieve the confidence levels required.

Q23. Are eligibility reviews totally separate from claims reviews in the FFS and managed care reviews? Are claims in cases reviewed for eligibility included in FFS and HMO claims reviews?

A23. The samples selected for the eligibility, FFS and managed care samples are separate. For eligibility, we estimate that each State will need to review an annual sample size of 504 active cases and 200 negative cases per program. We also estimate that we need to review an annual claims sample of 1000 FFS claims and 500 managed care claims per State per program. Each component, i.e., fee-for-service, managed care and eligibility will be used as the basis for the State's error rate.

Q24. Will the eligibility review methodology be the same – 500 for SCHIP and 500 for Medicaid? What eligibility elements specifically will be reviewed?

A24. The sample size for each State is 504 active cases and 200 negative cases per program. States should refer to the eligibility instructions included on this web site regarding specific review requirements.

Review Methodology

Q25: What is the distinction between a sample month and a review month when dealing with redeterminations?

A25: There is no distinction because redetermination cases are sampled and reviewed as of the State's last action. In cases placed in stratum two redeterminations, the sample month and review month are the same.

Q26: For States with a section 1634 agreement, should SSI conversion recipients be selected in Stratum 1 or Stratum 2? In some States, recipients who lose cash benefit due to SSA COLA remain Medicaid eligible for 30-60 days (SSI conversions - responsibility is transferred from SSA to the state) until the State Agency officially determines eligibility.

A26: The SSI conversions would be considered new applications for Medicaid and placed in stratum one. Federal policy does not provide for a 30-60 day automatic eligibility status. For SSI conversion cases, whether the loss of SSI is due to cost-of-living adjustments or any other reason, Federal regulations at 42 CFR 435.1003 limits Federal financial participation as follows: (1) to the end of the month after notification if the State receives the notice before the 10th of the month; or, (2) until the end of the next month if the State receives notification after the 10th of the month. The regulations require a prompt redetermination of eligibility when SSA notifies the States that a person has been determined ineligible for SSI. (In section 1634 States, Medicaid eligibility depends on receipt of SSI cash, when SSI case is lost, then Medicaid eligibility no longer exists on the basis and the State must redetermine eligibility to see if the person is eligible under another category.) The payment reviews for these cases must consider these regulations limiting Federal financial participation.

Q27: If a State pays the employee share of family insurance coverage, and provides fee-for-service wraparound services to the full scope of benefits, how should these family-level costs be treated under the PERM payment review process?

A27: The State should assign the share of cost to the working person in the family for whom the insurance is being provided by the employer. If that person is randomly sampled for review under PERM, the share of cost paid by the State would be included in the payment review along with any other services paid by Medicaid. The reason the share of cost is included for the working person is because, if that person is ineligible for Medicaid, the State should not be paying his/her insurance premiums.

If another family member is randomly sampled, the payment review would only include the services paid by Medicaid. The share of cost payments would not be included because, if this family member was ineligible for Medicaid, the employee's premium payment for the family made by the State would not necessarily be in error since the employed family member and other family members may retain program eligibility.

Q28: If a State has contracted with an insurance agency to provide health insurance coverage to its Medicaid/SCHIP recipients for a monthly premium, but also makes fee-for-service payments for these recipients, what payments do the State collect for the payment review?

A28: The State should collect the monthly premium paid to the insurance agency AND all other payments made for services in the month for the payment review.

Medicaid Eligibility Quality Control (MEQC) and PERM

Q29. States strongly encourage CMS to continue solutions related to the duplicative efforts between PERM and MEQC.

A29: CMS has done extensive analysis regarding the PERM/MEQC duplication of effort. In order to more actively involve States, we are forming a PERM Technical Advisory Group (TAG). It is our intention to focus our initial meetings for States to discuss ways to integrate PERM and MEQC.

Q30. Could CMS explain further why they will not permit the PERM eligibility review to be considered an MEQC "pilot" in the year that State is selected for PERM?

A30. The intent of the MEQC pilots is to provide States the opportunity to target reviews of vulnerabilities and error-prone or high dollar areas specific to the Medicaid program in each State. If all States conduct PERM reviews, the intent of the MEQC pilots is not met. Also, MEQC pilots do not encompass the State Children's Health Insurance Program (SCHIP) and, for purposes of PERM, Medicaid and SCHIP are measured separately.

Q31. States remain concerned with the response as to why PERM needs to create a separate eligibility review process, and why they can not use the same type of process as was used in the PAM/PERM Pilots. How and when are the best mechanisms to discuss this further?

A31. CMS created a separate eligibility review process to comply with the IPIA, which calls for measuring improper payments due to ineligibles. If we used the MEQC program to measure improper payments based on Medicaid ineligibles, all States would be required to use the traditional MEQC process and could potentially be subject to Federal disallowances. In addition, the MEQC program does not measure SCHIP eligibility. We believed a consistent approach to the eligibility measurement for both programs was desirable. Therefore, through the eligibility workgroup, we created an eligibility process that is less stringent and less costly than the MEQC process. States that wish to discuss changes to the eligibility process should do so via conference calls with the PERM TAG that CMS is forming.

Agency Independence for the PERM Eligibility Measurement

Q32. A few States on the APHSA call on March 8, 2007 thought that PERM had to report to a different division director than the head of eligibility and others thought that PERM had to report to a different upper level supervisor (not unit supervisors). Can CMS clarify this requirement?

A32. Each State must determine and ensure that the agency and personnel that develop, direct, implement, and evaluate the PERM eligibility reviews and associated activities are functionally and physically separate from the State Agencies and personnel that are responsible for Medicaid and SCHIP eligibility determinations, policies and operations. Below are some examples that should help provide clarification:

- The agency responsible for the PERM eligibility reviews and operations report to a supervisor who is separate from the supervisor of the State agency responsible for the eligibility determinations, policies and operations. The agency responsible for the PERM (PERM agency) measurement is physically located in a separate office from the State agency. The PERM agency can report to the office head, e.g., upper management who reports directly to the State Medicaid Director and who also is in charge of the State agency responsible for the eligibility determinations, policies and operations. The PERM agency should not report to the same immediate supervisor as the State agency.

- A Department in the State enters into an arrangement (formally through a Memorandum of Understanding (MOU) or on a more informal basis) with another Department to be responsible for the PERM eligibility reviews and operations, but that Department reports to a separate supervisor who is considered upper management.

- The State contracts with an outside entity to conduct the PERM eligibility reviews, and the contractor is not overseen by the State agency responsible for Medicaid and/or SCHIP eligibility determinations, policies and operations and the contractor reports to a separate agency head or other separate top management.

Q33. States appreciate and support that CMS is providing States with as much flexibility as possible. However, States are concerned that they may be penalized in the future for having an inappropriate eligibility PERM organizational reporting structure.

A33. CMS will not penalize States in this matter.

Q34. Is it correct that a person not currently responsible for the eligibility reviews but who works in a Department can do the eligibility reviews as long as they are not supervised by the person currently responsible for the review?

A34. If the person conducting the PERM reviews is not under the supervisor of the State agency that is responsible for the eligibility determinations, policies and operations, and is housed in an agency that is physically and functionally separate from the State agency, the arrangement should be acceptable.

Q35. If a State has a MOU with another agency to perform eligibility and this agency also does the MEQC, can we have the staff that performs the MEQC also perform the PERM if they report to a low level supervisor who is different from the low level supervisor who is responsible for eligibility? If not, does this mean that the Agency has to hire new staff to run the PERM?

A35. We do not encourage the use of MEQC staff to conduct the PERM eligibility reviews because this approach would require States to reduce or divert MEQC staff for PERM purposes. CMS is not requiring States to hire new staff to operationalize the PERM eligibility measurement.

Q36. Does negative case action reviews apply to both Medicaid and SCHIP managed care? Will CMS consider these reviews in PERM to satisfy Medicaid Eligibility Quality Control (MEQC) requirements as well?

A36. The negative case action reviews apply to individuals enrolled in Medicaid and SCHIP FFS and/or managed care. The negative case sample for eligibility includes all cases that were denied or terminated. In a year a State conducts the negative case action reviews under PERM, these PERM reviews will be considered to meet the negative case action requirements under MEQC. This will eliminate duplication of the negative case action reviews and minimize cost and burden for the States.

DISPUTE RESOLUTION PROCESS

Q1. Can CMS provide more clarification on the dispute resolution policy in relation to the medical reviews? For FY 2006 States, a summer release is very late. States are looking for information as to how the medical review errors will be handled this year, to include the appeal process. We have not yet had our introductory call with the medical reviewer.

A1. The review contractor expects to release guidance on the dispute resolution process within the next several weeks. CMS will have calls with the States to review this guidance. All States had introductory calls with the contractors, including the review contractor.

CMS Appeals

Q26. What is CMS learning from reversals in the appeals process? Is CMS planning to make systematic changes to its processes to address these findings?

The CMS-level appeals process is still very new and CMS will make changes as warranted. To date, several issues have been identified and have been addressed as follows:

- Some capitated payments have gone through medical review and should not have. CMS is working on identifying these claims early in the process so that they do not go through medical review in the future.
- In some instances, the beneficiary did not meet medical necessity for inpatient hospitalization. Instead of viewing the total claim amount as an error, CMS is working to credit the States for the appropriate charges for observation.
- In some instances, the State's Medicaid program does not cover observation status. CMS is working on identifying these States early in the process so that this difference in determining medical necessity may be accounted for.

Updating State Contact Information

Q25. How do I formally notify and/or update CMS of the back-up or additional back-up person to receive all finding notices?

A25. Please contact HDI to submit the back-up or additional back-up contact information. HDI can be reached at (410) 221-9990.

Q26. How do the states update their contact lists for the individuals who are responsible for the specific areas (medical review & claim processing) and their back-ups to review their state Disposition Record and file a Notice of Difference? Also, what is the process of acquiring their state specific password in order to access the SMERF web site?

A26. States will contact the appropriate contractor to update their contact lists for the specific areas. In regards to disposition record and notice of difference, please contact HDI to update contact information. HDI will also be the point of reference to acquire the state specific password to access SMERF.

CMS FEDERAL CONTRACTORS

Q1. How can we contact the PERM contractors?

A1. The list of contacts for the PERM contractors is available on the PERM website (www.cms.hhs.gov/perm).

Q2. Who is the contact with Livanta on claims?

A2. Inquires may be directed to Livanta's Project Director for PERM, Pamela Applegate at 301-957-2319 or papplegate@livanta.com.

MEDICAL RECORDS REQUESTS

Q1. Will States receive the documents for the claims reviews from the providers and forward those documents to the contractor?

A1. No. The request for medical records will be issued by CMS' documentation/database contractor and sent directly to the providers. The provider is responsible for submitting copies of the requested medical records to the documentation/database contractor.

Q2. Do States get copies of all correspondence that the documentation/database contractor is sending to Medicaid providers so States know the process for requesting medical records?

A2. States do not get copies of all correspondence requests sent to State Medicaid providers since the paperwork would be voluminous and cost prohibitive (e.g., the documentation/database contractor can send up at a minimum of 4 written requests for medical records over the current 90-day timeframe that the providers are given to submit them). In addition, the inclusion of personal identifiable information makes it difficult to provide letters to States without stringent controls in place to protect the privacy of the beneficiaries. However, the documentation/database contractor (Livanta) is currently developing a website that will provide States with the ability to track requests made to providers for medical records.

Q3. How much time do providers get to submit requested documentation? Are documentation checklists sent with the requests, so the providers know what they are expected to provide?

A3. Currently, providers are given 90 calendar days from the date of the letter requesting the medical records to submit them. In the request for medical records, the documentation/database contractor provides a documentation checklist with each request. The contractor also follows up with providers with phone calls and letters several times throughout this timeframe. Currently, most medical records are submitted promptly and the provider response rate is good.

RECOVERIES OF OVERPAYMENTS

Q1. If, for example, a State's Medicaid error rate is 2%,is there an extrapolation, i.e., do States have to return 2% of all Federal Medicaid funds paid to them during the PERM year?

A1. The PERM program does not change, revise or alter the current statutory recovery requirements for Medicaid and SCHIP regardless of a State's error rate.

Q2. If the PERM error rate is over zero, are there consequences? CMS's response was that it will not pursue recovery for Medicaid, but will require recovery for SCHIP. If so, this is in conflict with previous written communications from CMS and responses in the Federal Register, therefore we need to have written documentation.

A2. For Medicaid fee-for-service and managed care overpayments, States must return to CMS the Federal share of overpayments based on medical and processing errors in accordance with section 1903(d)(2) of the Social Security Act and related regulations at part 433, subpart F in the Code of Federal Regulations. Similarly, SCHIP improper payments based on medical, data processing and eligibility errors are recovered in accordance with section 2105(e) of the Act and related regulations at part 457, subpart B of this chapter. However, overpayments related to Medicaid eligibility reviews are governed by section 1903(u) of the Act, which are the requirements relating to the MEQC program.

Q3. Can CMS explain how the determination and recovery of payments for eligibility errors will work for SCHIP? Would the payments that need to be returned to CMS be only for the month of review? Will eligibility errors for Medicaid not result in any pay back of dollars paid out for the review month?

A3. SCHIP overpayments for eligibility errors are governed by section 2105(e) of the Act, not the PERM program. Recovery of overpayments resulting from Medicaid eligibility errors are governed under the MEQC provisions of the Social Security Act, not the PERM program.