



SHO #04-001

July 13, 2004

Response Requested by August 26, 2004

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is pleased to solicit proposals from states interested in participating in pilot testing the Payment Error Rate Measurement (PERM) program. As both a requirement of the Improper Payments Information Act of 2002 (Public Law 107-300) and a Government Performance and Results Act (GPRA) goal, CMS is committed to developing and implementing a PERM methodology that can be used to estimate the payment error rate in both the Medicaid program and the State Children's Health Insurance Program (SCHIP) at the state and national levels.

Beginning in fiscal year (FY) 2006, the PERM program will be implemented nationwide. In preparation for the implementation of PERM, CMS solicited states in FY 2002 – FY 2004 to conduct payment accuracy measurement demonstration projects. It is through these demonstration projects that the PERM methodology was developed. In our continuing effort to help states prepare for the nationwide implementation of PERM, CMS is offering states the opportunity to participate in a PERM pilot during FY 2005. We believe this pilot project will provide states with a valuable opportunity to gain experience and familiarity with the PERM methodology prior to implementation. Therefore, we strongly encourage state participation in the FY 2005 PERM pilot, particularly among those states that have not participated in the previous pilot projects.

As in the past three years, states will receive 100 percent Federal funding for all expenses incurred through participation in the PERM pilot; therefore, no state financial contribution will be required. State expense will be funded through a combination of Federal financial participation and Health Care Fraud and Abuse Control (HCFAC) grant funding as reimbursement for what would otherwise be the state share (the Federal share will continue to be paid through the regular administrative matching process). For the FY2005 PERM pilot, CMS anticipates that it will have no more than \$2.5 million in HCFAC funds to reimburse the cost of participation for twenty-five or more states. Because the sample sizes in the PERM pilot will be considerably smaller than in previous years, we anticipate project costs to decrease substantially.

In order to maintain consistency with the expected requirements of the PERM program, states are expected to pilot test the methodology in both the fee for service (FFS) and managed care

(MC) components of their Medicaid and SCHIP programs. For each program, states will be expected to review a statistically valid sample of approximately 150 claims/line items, divided proportionally between the FFS and MC components. Based on these results, states will then be expected to estimate the payment error rate in their Medicaid and SCHIP programs. Each state's payment error rate estimate will contribute to the calculation of a national payment error rate for each program.¹ Considering that CMS will use the state results in its calculation of a national error rate, states will be required to adhere to the procedures and guidelines as detailed in the model.

Applications for the PERM pilot are due 45 calendar days from the date of this letter. Applications may be submitted by the state Medicaid agency, the agency that administers the SCHIP program, or another state agency in partnership with the Medicaid agency. Participation is open to all states, regardless of prior participation in the project, but applications from states that have not participated in the payment accuracy measurement demonstration project are especially encouraged. States that have previously participated must submit a new application to be considered for the PERM pilot. CMS anticipates announcing the awards by September 30, 2004.

The PERM pilot requires the collection and review of protected health information contained in individual-level medical records for payment review purposes. This is permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and by the Privacy Rule regulations at 45 CFR Parts 160 and 164.

The Program Announcement is enclosed. If you have questions or need additional assistance, please contact Christine Saxonis, Project Lead, at (410) 786-3722 or e-mail: csaxonis@cms.hhs.gov.

We look forward to working with you to enhance the efficiency of the Medicaid and SCHIP programs!

Sincerely,

/s/

/s/

Timothy Hill
Director, Office of Financial Management

Dennis Smith
Director, Center for Medicaid and
State Operations

Enclosure

cc:

CMS Regional Administrators

¹ A sample size of 150 line items should result in an estimate of the error rate that is within about +/- 6 percentage points of the true error with 90% confidence at the state level.

Page 3– State Health Official

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PAYMENT ERROR RATE MEASUREMENT (PERM) SOLICITATION
INITIAL SOLICITATION ANNOUNCEMENT

**To pilot test a methodology that will be used by all states to determine error rates for the
Medicaid and State Children's Health Insurance Programs.**

Funding Opportunity Number CMS-04-005

CFDA No. 93.779
Application due date August 26, 2004

TABLE OF CONTENTS

	Page
Timetable	3
Executive Summary	4
Purpose	7
Background	7
Protocol	9
Funding	21
Eligible Applicants	21
Cost Sharing or Matching	22
Application and Submission Information	22
Submission Dates and Times	23
Funding Restrictions	23
Review Criteria	24
Award Date	26
Award Administration Information	26
Agency Contacts	28
Appendix A	29
Appendix B	30
Appendix C	41

PROGRAM ANNOUNCEMENT

OVERVIEW INFORMATION:

Agency Name: Department of Health and Human Services/Centers For Medicare & Medicaid Services/Office of Financial Management

Funding Opportunity Title: The Payment Error Rate Measurement (PERM) Solicitation

Announcement Type: Initial Solicitation

Funding Opportunity No.: CMS-04-005

Catalog of Federal Domestic Assistance No. (CFDA): 93.779

Dates:

Date of Issue	July 13, 2004
Proposal Due Date	August 26, 2004
Award Announcement	September 30, 2004
Grant Period	September 30, 2004 – September 29, 2005

Executive Summary

Medicaid and SCHIP Payment Error Rate Measurement (PERM) Pilot Demonstration Project CFDA – 93.779

The Centers for Medicare & Medicaid Services (CMS) is pleased to solicit proposals from states interested in participating in a pilot test of the PERM program during FY2005. CMS has been successfully conducting payment accuracy measurement demonstration projects with states for three years in order to develop the PERM methodology that we anticipate implementing nationwide through regulation in FY2006 in Medicaid and the State Children's Health Insurance Program (SCHIP).

In the FY2005 PERM pilot, CMS intends to further refine and pilot test the methodology in both the fee-for-service (FFS) and the managed care components of the Medicaid and SCHIP programs in 25 or more states. The PERM pilot will provide states with the opportunity to gain experience and familiarity with the methodology prior to anticipated nationwide implementation in FY2006. Working with the participating states, CMS also intends to develop the final specifications for the methodology and the program manuals for the PERM program regulation. Finally, CMS intends to use the findings from each state to produce national level estimates for the Medicaid and SCHIP programs in order to comply with the requirements of the Improper Payments Information Act of 2002 (IPIA).

As in the past three years, states will receive 100 percent Federal funding for expenses incurred through participation in the PERM pilot; therefore, no state financial contribution will be required. States will be supported through a combination of Federal financial participation (FFP) and Health Care Fraud and Abuse Control (HCFAC) grant funding as reimbursement for what would otherwise be the state share.¹ The grant award will be available in a subaccount reserved for each state within the Payment Management System (PMS). The Federal share (FFP) will continue to be paid through the regular administrative matching process.

Importantly, for the FY2005 PERM pilot, CMS has approximately \$2.5 million in HCFAC funds to reimburse the state share of the costs of participation for twenty-five or more states. Because the sample sizes in the PERM pilot will be considerably smaller than in previous years, we anticipate project costs will be substantially less. Therefore, to ensure that we have adequate funding for 25 or more states, we are asking states to limit their request for HCFAC grant funding to \$100,000. States that submit applications with budgets in excess of these limits will be considered only as funding permits.

¹ Because these are administrative expenditures, the grant award is based on the assumption that the state share represents 50 percent of the total cost of the pilot for Medicaid participation and 15 to 50 percent of the total cost of the pilot for SCHIP participation (depending on whether the state elects to claim FFP for administrative expenses at the Title XXI enhanced FMAP rate, subject to the 10 percent cap, or at the applicable Medicaid administrative matching rate, in this case 50 percent).

As both a Government Performance and Results Act (GPRA) goal and a requirement of the Improper Payments Information Act of 2002 (Public Law 107-300), CMS has been committed to developing and implementing a methodology that can be used to estimate payment error in both Medicaid and SCHIP at the state and national levels. Working with our technical consultant, The Lewin Group, and the states that have participated since FY2002 in the payment accuracy measurement demonstration project, we developed the PERM methodology. The PERM methodology is designed to estimate payment error at the state and national levels in both the FFS and the managed care components of the Medicaid and SCHIP programs.

The PERM methodology was initially pilot tested in FY2003 by the 12 states that participated in the second year of the payment accuracy measurement demonstration project. During this year, we also modified the methodology to comply with the IPIA and the related OMB guidelines. As a result, the methodology was modified to estimate payment error in both Medicaid and SCHIP. Additionally, because the guidelines define erroneous payments to include overpayments, underpayments, and payments made to ineligible beneficiaries, the PERM methodology was also modified to account for payment error attributable to all three of these factors. Therefore, in the methodology, sampled claims/line items are subjected to three forms of review: processing validation; medical review; and eligibility verification (eligibility verification is conducted on the beneficiaries associated with the sampled claims/line items in a manner that is consistent with the requirements of the Medicaid Eligibility Quality Control program). In FY2004 we are pilot testing the modified methodology in 27 states. During this year, 11 states are pilot testing the methodology in their Medicaid program; 3 states are testing the methodology in their SCHIP programs; and 13 states are testing the methodology in both of these programs.

In order to maintain consistency with the expected requirements of the PERM program, we are encouraging states during FY2005 to pilot test the methodology in both the FFS and managed care components of their Medicaid and SCHIP programs. States that choose to pilot test the methodology in both components of these programs will be given preferential consideration; states that choose not to participate in both programs must submit an explanation for exemption along with their application.

States will be expected to review random samples of 150 claims/line items for payment error from each program (i.e., 150 claims for Medicaid and 150 claims for SCHIP). States that have managed care and FFS components of their program will divide this 150 relative to the proportion of program dollars spent on each component. For example, if a state incurred two-thirds of its Medicaid spending for the FFS program and one-third for its capitated managed care program, the state would draw 100 claims from the FFS universe and 50 from the managed care universe. From the review findings, each state will also be expected to estimate a payment error rate in their Medicaid and SCHIP programs. The estimates from each state sample will allow for the calculation of a national level payment error rate in each program.² In the PERM pilot, states will select 50 claims each month (i.e. October, November and December 2004) from the universe.

² A sample size of 150 line items should result in an estimate of the error rate that is within about +/- 6 percentage points of the true error with 90% confidence at the state level.

In addition, to better understand the differences between state findings and ensure uniformity in the application of the methodology, the Delmarva Foundation, subcontractor to The Lewin Group, will be conducting a re-review of 25-50 claims from each state towards the end of the project period. Therefore, states are asked to adhere to the required procedures and guidelines as detailed in the model.

Applications for the PERM pilot are due no later than 45 calendar days from the date of this letter. Applications may be submitted by the state Medicaid agency, the agency that administers the SCHIP program, or another state agency in partnership with the Medicaid agency. Participation is open to all states and the District of Columbia, regardless of prior participation in the project; however, applications from states that have not participated in the payment accuracy measurement demonstration project are especially encouraged. States that have previously participated must submit a new application to be considered for the PERM pilot. CMS will announce the awards by September 30, 2004. The funding period is for 12 months from September 30, 2004 through September 29, 2005. The territories will be excluded from participation in the FY2005 PERM pilot test.

The collection and review of protected health information contained in individual-level medical records for payment review purposes, as required by the PERM pilot, is permissible by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing Privacy Rule regulations at 45 CFR Parts 160 and 164.

States receiving awards must agree to cooperate with any evaluation of the product of the work and to provide required information and reports in a format prescribed by CMS. States shall submit quarterly progress reports that are due 30 days after the end of the quarter. States shall also submit a final project report due 30 days after the end of the project; the final report may be submitted in lieu of the fourth quarter report. In addition, Project Directors or other appointed representatives are expected to participate on scheduled conference calls with the demonstration project team and attend one PERM pilot conference. The PERM pilot conference will be held in the Baltimore/Washington DC area and will be used as a forum for team members to present project progress reports, discuss findings, and address administrative concerns.

FULL-TEXT OF ANNOUNCEMENT

I. Funding Opportunity Description: Request for Proposals

A. Purpose

The purpose of the Centers for Medicare and Medicaid Services' (CMS) Payment Error Rate Measurement (PERM) pilot is to further refine and pilot test the methodology in both the fee-for-service (FFS) and the managed care components of the Medicaid and State Children's Health Insurance (SCHIP) programs in 25 or more states during FY2005. The PERM pilot will provide states with the opportunity to gain experience and familiarity with the methodology prior to anticipated nationwide implementation in FY2006. Working with the participating states, CMS also intends to develop the final specifications for the methodology and the program manuals for the PERM program regulation. Finally, CMS intends to use the findings from each state to produce national level estimates for the Medicaid and SCHIP programs in order to comply with the requirements of the Improper Payments Information Act of 2002 (IPIA).

Essentially, the payment error rate measurement enables the government to identify the amount of money that has been inappropriately paid, identify and study the causes of the inappropriate payments, and focus on strengthening internal controls. At the state level, states will be able to estimate the payment error rates in their Medicaid and SCHIP programs. In addition they will identify existing and perhaps emerging vulnerabilities that can be targeted with the appropriate corrective actions. At the national level, CMS will be able to estimate the extent of the inappropriate payments and produce an overall payment error rate estimate for the Medicaid and SCHIP programs.

CMS is soliciting proposals from states to participate in the FY2005 PERM pilot.

B. Background

The IPIA directs each executive agency, in accordance with the Office of Management and Budget (OMB) guidance, to review all of its programs and activities annually, identify those that may be susceptible to significant improper payments, estimate the annual amount of improper payments, and submit those estimates to Congress before March 31 of the following applicable year.

For each program or activity with estimated improper payments exceeding 2.5 percent and \$10 million, each agency is required to provide an annual estimate of improper payments and a report on agency actions to reduce improper payments, including: (1) a discussion of the causes of the improper payments and the results of the actions taken to address those causes; (2) a statement of whether the agency has adequate information systems and other infrastructure; and (3) a description of the steps the agency is taking to ensure that managers are held accountable for reducing improper payments.

In Exhibit 57B of OMB Circular A-11, programs for which improper payment information is requested within the Department of Health and Human Services include: Head Start, Medicare,

Medicaid, Temporary Aid to Needy Families (TANF), Foster Care Title IV-E, SCHIP, and the Child Care and Development Fund.

In order to comply with the definition of improper payments cited in the IPIA and OMB guidance, Federal agencies are expected to provide estimates of improper payments. Improper payments are defined as: (a) any payment that should not have been made or that was made in an incorrect amount, including both overpayments and underpayments, under statutory, contractual, administrative, or other legally applicable requirements; and (b) payments made to an ineligible recipient, any duplicate payments, payments for services not received, and any payment that does not account for credit for applicable discounts.

CMS has been estimating improper payments in the Medicare program since 1996 as part of the Chief Financial Officer's Audit conducted annually by the Office of Inspector General (OIG). The Comprehensive Error Rate Testing Program, which was implemented in phases, assumed responsibilities for producing the annual improper payment estimate for the Medicare program beginning in FY 2003.

In fiscal year (FY) 2000, CMS adopted a Government Performance and Results Act (GPRA) goal to explore the feasibility of developing a methodology to estimate improper payments for the Medicaid program. During that year, the Center for Medicaid and State Operations (CMSO) initiated the payment accuracy measurement demonstration project. Prior to the first year of the project only three states, Illinois, Texas, and Kansas, had attempted to estimate payment error for the Medicaid program at the state level, and no model had been developed to estimate payment error at the national level.

In July of 2001, CMS formally solicited states to participate in the first year of the demonstration project. Using a combination of FFP and Health Care Fraud and Abuse Control (HCFAC) grant funds, nine states were awarded grants to develop and pilot test various methods for measuring payment error in the Medicaid program. In the first year of the project (FY 2002), the nine participating states were given considerable flexibility in the design of their methodological approaches. Many states adopted similar approaches that were based on the Illinois, Kansas, and Texas studies. Some of the states built upon previous state initiated studies. However, most of the states in the project attempted to address unique state concerns and circumstances.

During the first year of the project, CMS also contracted with The Lewin Group as the technical consultant to the project in order to work with the states and to help develop a single methodology that can be used by all states. Working collaboratively with the nine states, CMS and The Lewin Group developed a methodology designed to estimate a state-specific payment error rate that is within +/- 3 percent of the true population error rate with 95 percent confidence. Moreover, through weighted aggregation, the state-specific estimates can be used to make national level payment error rate estimates in both the FFS and managed care components of the Medicaid and SCHIP programs.

In May 2002, CMS solicited states to participate in the second year of the project (FY 2003). Twelve states were awarded grants to pilot test the standard methodology in Medicaid. Notably, 8 of the 12 Year 2 states also participated in the first year of the project. Each of the 12 states pilot tested the methodology and produced state-specific estimates at the required precision level.

In June 2003, CMS solicited states to participate in the third year of the project (FY 2004). Twenty-seven states were awarded grants to pilot test the methodology in both Medicaid and SCHIP. Each of the 27 states is pilot testing the methodology; of these 27 states, 11 are pilot testing the methodology in their Medicaid programs, 3 are testing in their SCHIP programs, and 13 are testing in both programs.

C. Payment Error Rate Measurement Protocol

1. Payment Error Rate Measurement: Overall Approach

Simply defined, payment error is the ratio of the dollar value of payments paid in error to the dollar value of total payments made. Inaccurate payments can include both overpayments and underpayments.³ The basic steps of payment error rate measurement methodology consists of:

- drawing a stratified random sample of sampling units from each universe of FFS Medicaid and SCHIP claims and capitation payments in the state;
- reviewing each sampling unit to determine the accuracy of the payments made; and
- computing a payment error rate based on the sample, where the error rate is defined as the ratio of the expected dollar value of payments paid in error to the dollar value of total payments made.

The methodology has been designed to estimate payment error for both the FFS and managed care components of the Medicaid and SCHIP programs and to comply with the requirements of the IPJA and the related guidelines from OMB. The methodology implemented in the PERM pilot will consider both paid and denied sampling units and include an eligibility review of a sub-sample of beneficiaries whose claims are included in the sample. The payment error rate estimate will be the gross total of both over and underpayments.

The following methodology describes the CMS PERM model for reviewing FFS and managed care payments in Medicaid and SCHIP. Each state will estimate a state error rate. The state error rates will be aggregated across states to calculate a national measure of payment error. In Section 1 below, we describe the CMS PERM Model for FFS payments. In Section 2, we describe the CMS PERM Model for capitated payments under managed care.

³ Underpayments include those instances in which a provider's claim was improperly reduced by the Medicaid claims processing system, either manually or through the automated edits, and, upon re-review for the PERM pilot, it is concluded that a higher payment was justified. The difference between the two amounts would be the underpayment. For example, if a provider submits a claim for the maximum allowable charge of \$100 but the claims processing system pays only \$50, and upon a PERM review of the medical records it is determined that the full \$100 should have been paid, then the \$50 difference will be considered an underpayment. On claims where the maximum allowable charge is less than the submitted charge but greater than the amount paid by the claims processing system, the difference between the maximum allowable charge and the paid amount is the underpayment.

2. Payment Error Rate Measurement Model: Fee-for Service Claims

In this section, we describe the CMS PERM model and key features for selecting and reviewing FFS claims. This model is applicable to both Medicaid FFS and SCHIP FFS programs.

A. Key Components and Parameters

1. Universe

The “universe” of claims is the set of claims from which the sample is drawn, and the set of payments for which the error rate is inferred from the sample. The Medicaid FFS claims universe, from which the sample is to be drawn, consists of all adjudicated FFS Medicaid claims or invoices for which FFP at Title XIX matching rates was claimed (for paid claims) or would have been claimed (for denied claims). That is, any claim paid for in part by Federal dollars should be included in the universe, or population, of claims to be sampled. The universe, however, excludes any non-claims based payments as well as disproportionate share payments, aggregate cost settlement payments, and any other expenditure that is not a payment to a provider for services provided for a beneficiary. Adjustments to claims are also excluded from the universe for sampling purposes, but adjustments to a sampled line item that occur within 60 calendar days after the payment adjudication date for that line item should be included for review purposes.⁴

The same general criteria for defining the “universe” are also applied to SCHIP. The SCHIP FFS claims universe, from which the sample is to be drawn, consists of all FFS SCHIP claims or invoices for which FFP at Title XXI matching rates was claimed (for paid claims) or would have been claimed (for denied claims). For FFS SCHIP programs that are a Medicaid expansion, the claims for children in the expansion group(s) are generally co-mingled with other Medicaid FFS claims. The SCHIP claims (for which FFP was sought) should be separated from Medicaid claims subject to Title XIX FFP and errors among claims for children in the expansion group(s) should be separately tracked. In addition, for FFS SCHIP programs that are a separate state program, the claims for the separate program should be considered their own universe. A separate sample should be drawn from this universe and errors among claims for children in the separate program should be separately tracked.

2. Time Period for Sampling

The sample shall be drawn from a universe of all claims properly adjudicated during the first quarter of the Federal fiscal year. Therefore, all claims adjudicated between October 1, 2004 and December 31, 2004, inclusive, will be included in the universe for sampling purposes. In the PERM pilot, states will select 50 claims each month from the universe.

⁴ The state may choose to begin the review of a line item before the 60-day window for accepting adjustments is complete. However, if the state does this, it should discern whether any adjustment by the provider subsequent to beginning the review was triggered by the review itself. If so, it should not allow that particular adjustment for the purposes of computing the PERM model error rate.

3. *Sampling Unit*

The sampling unit will be the “line item” or service. An actual claim may consist of several line items or services. Independently priced line items will constitute the sampling unit. (Items simply listed as included in a bundled service would not be considered “line items” for this purpose.)

It is assumed that the state can sample at the “line item” or service level. Sample sizes and sampling plans are predicated on sampling at the line item level. If the state can draw samples only at the “claim” level, the sampling unit is the claim, which includes the review of all line items on the claim.⁵

4. *Sampling Plan*

The overall sample size will be 150 claims per program (i.e., 150 claims for Medicaid and 150 claims for SCHIP). States that have managed care and FFS components of their program will divide this 150 relative to the proportion of program dollars spent on each component. For example, if a state incurred two-thirds of its Medicaid spending for the FFS program and one-third for its capitated managed care program, the state would draw 100 claims from the FFS universe and 50 from the managed care universe. In the PERM pilot, primary care case management is considered FFS, not managed care. The states may propose sample sizes in excess of 150 line items per program, but CMS cannot guarantee full Federal funding for that portion in excess of 150.

For states that participated in earlier years of the payment accuracy measurement demonstration project, note that this sampling plan is a significant departure from the approach used in previous years, in which states were asked to calculate a sample size that would allow the estimation of a state-level payment accuracy rate at a pre-specified level of precision. This generally resulted in sample sizes of 800 to 1200 claims. The sample size proposed for the PERM pilot will not allow states to calculate state-specific rates at 95 percent confidence plus or minus three percent. States that wish to review larger samples will be allowed to do so; however, CMS may only be able to fully fund the portion of the study relating to the 150 desired claims per program.⁶

⁵ The accuracy of paid line items on a claim is not likely to be independent. That is, if one line item on a claim is found to have been paid in error, the probability that another item on the same claim is in error is greater than that for an item picked at random from another claim. Hence, the standard error of an estimate of the error rate based on a sample of 1000 line items is likely to be greater if the sample size is made up of all the items on about 300 claims, compared to a sample where each of the 1000 line items is independent of the claim on which it appears. For this reason, we are reluctant to count more than one line item from a claim in determining sample size. Our recommended alternative of reviewing all line items on the claim but counting the result as only one sampling unit will “oversample” to some (unknown) extent, depending on the correlation of the accuracy of individual line items on a claim. However, to count all the line items from a single claim toward the same sample size is likely to overstate the information provided by the sample, compared to a sample of line items of the same size that is independently drawn.

⁶ A sample size of 150 line items will prove an estimate of the error rate that is within about +/- 6 percentage points of the true rate, with about 90% confidence.

A proportional, stratified random sample will be drawn for Medicaid FFS. Stratification is not required for the SCHIP sample, but states may choose to stratify claims using the Medicaid strata definitions or a state-designed stratification approach. The Medicaid sampling strata include:

- inpatient hospital services;
- long-term-care services;
- other independent practitioners and clinics;
- prescription drugs;
- home and community-based services;
- other services and supplies; and
- fixed payments on behalf on individual beneficiaries (e.g., primary care case management payments, Medicare Part A and Part B premiums), if applicable.

Appendix A provides a breakout of the services and supplies that map into each of the strata.

The sample sizes by stratum should be proportional to the dollar value of the line items represented by each stratum for the most recent four quarters.⁷ That is, if inpatient hospital services represent 30 percent of the dollar value of total Medicaid claims, 30 percent of the sample of line items should come from the inpatient stratum. Note that this will result in oversampling in strata for which the proportion of Medicaid payments is greater than the proportion of Medicaid line items, and undersampling in those strata for which the proportion of line items is greater than the proportion of Medicaid payments. When calculating the payment error rate, this over- and under-sampling by strata must be taken into account in calculating an unbiased estimate of the overall payment error rate.⁸

If the state has both a FFS and managed care component in its Medicaid or SCHIP program, the FFS sample will be stratified, but the total FFS sample size will be that proportion of the 150 line items that represents the FFS dollar share of Medicaid (or SCHIP). For example, if FFS represents two-thirds of the Medicaid by dollar value, 100 line items would be allocated to the FFS sample and 50 line items would be included in the managed care sample. The FFS 100 items would then be stratified as discussed above. The 50 items in the managed care sample would not require stratification.

For purposes of the eligibility review (a component of the processing validation review), a sub-sample of cases from the sample of paid claims and/or line items will be selected. The sub-sample of beneficiaries should include at least 50 beneficiaries derived from the sampled claims or line items for each program (Medicaid and SCHIP). If the state will be applying the PERM model to both its FFS and its managed care programs, the number sampled from each should be proportional to the dollar value of each component.

⁷ This improves the precision of the estimate if the variance of the accuracy rate across strata is proportional to the Medicaid payment share represented by the stratum.

⁸ In particular, if $W^{s,j}$ is the proportion of total sampled line items represented by stratum j , and $W^{u,j}$ is the proportion of total line items in the universe represented by stratum j , then each line item should be weighted by $W^{u,j}/W^{s,j}$ when calculating the accuracy rate.

During the previous years of the payment accuracy measurement demonstration project, CMS has allowed states to obtain Medicaid Eligibility Quality Control (MEQC) waivers to allow them to substitute the demonstration project eligibility reviews for part of the state's MEQC level of effort, if the state conducts traditional MEQC reviews. However, if a state elects to substitute PERM pilot eligibility reviews for MEQC reviews, that effort is not funded under the PERM grant. Because program funds are limited, however, it may allow a state to "save" costs in that area, which will allow for the use of PERM funds for other uses under the grant.

B. Review

The review and audit should consist, at a minimum, of three components: processing review, eligibility review, and medical review. CMS will provide pilot states with MedQuest, an Access-based database that allows the user to track requests for medical review documentation and record case outcomes, including any errors found, in a systematic way.

1. Processing Review

Once the sample is drawn, each line item should be reviewed to validate that it was processed correctly, based on the information that is on the claim. Specific issues to address in the review include:

- duplicate item (claim);
- non-covered service;
- service covered by HMO (i.e., beneficiary is enrolled in managed care organization that should have covered the service);
- third party liability;
- invalid pricing;
- logical edits (e.g., incompatibility between gender and procedure);
- beneficiary eligibility (for sub-sample);
- data entry (clerical) errors; and
- other.

2. Eligibility Review

A randomly selected sub-sample of 50 beneficiaries per program shall be selected and reviewed for eligibility. Eligibility reviews will determine whether the beneficiary was eligible for Medicaid or SCHIP in the month the sampled service was provided (or on the date of service in states with date-specific eligibility). This includes:

- reviewing of the original eligibility case record materials; and
- any third party verification, beneficiary interviews, or other inquiries necessary to complete and/or validate any discrepancies or omissions in the case record.

Note that if any persons in the Medicaid eligibility sub-sample are eligible as an automatic by-product of eligibility for another program and eligibility is primarily determined by another agency, the state must merely verify with that agency that the beneficiary was eligible during the month of service. This may include the Social Security Administration for SSI recipients (in 1634 states), Title IV-E for adoption assistance/foster care cases, the Office of Refugee Resettlement for refugee cases that are 100 percent Federally funded, and state welfare agencies in states where eligibility for Temporary Assistance for Needy Families (TANF) cash assistance confers automatic Medicaid eligibility.

3. *Medical Review*

In addition, the line item should be subject to comprehensive medical review, which, at a minimum, includes:

- reviewing the guidelines and policy related to the claim;
- reviewing medical record documentation;
- a medical necessity review; and
- a coding accuracy review.

Medical record documentation requests to providers via mail are sufficient for this process; states may, at their option, conduct scheduled or “surprise” visits to provider offices in order to collect medical record documentation.

When errors are found, the dollar amount of the payment error and the reason for the error should be recorded. General guidelines for medical review of claims, along with reason codes for both processing and medical review errors, are included in Appendix B. The guidelines are relatively general and states are asked to adhere to these guidelines in their reviews.

The states are requested to help us in formulating better medical review guidelines by randomly selecting a subsample of 25-50 adjudicated line items for re-review. States will send the line items, the documentation, and the policies used in the original review. The results will be used to determine how review procedures might be improved in the future.

C. *Computation of the Payment Error Rate for Fee-for-Service Claims*

We ask that states submit information on the sample and universe size for each strata, and on any over- and underpayment errors identified. States can calculate state-level payment error rates using the formulas provided in Appendix C. CMS will calculate a national payment error rate.

If a state wishes to review a larger sample in order to calculate a state-level payment error rate with a higher level of precision, CMS can provide access to a sample size calculator and an error rate calculator developed during Year 3 of the payment accuracy measurement demonstration project.

D. Reporting

The following information for the FFS samples should be provided in the final report:

- the payment error rate;⁹
- its standard error and 95 percent confidence interval;
- point estimates of rate by stratum (if applicable);
- total sample size of the universe, measured by both number of items and dollar value;
- proportion of dollars and proportion of items represented by the universe in the sample;
- total sample size and sample size of each stratum (if applicable), measured by both number of items and dollar value;
- proportion of dollars and proportion of items represented by each stratum (if applicable), both in the universe and in the sample;
- dollar distribution of errors by reason and by over-payments versus under-payments;
- projected estimate of total over- and under-payments for the period of inference; and
- findings and observations resulting from the analysis.

3. Payment Error Rate Measurement Model: Capitated Managed Care

A. Key Components and Parameters

1. Universe

Each state enrolling beneficiaries in fully- or partially-capitated managed care enrollment options should include capitation or premium payment transactions within the scope of its payment error measurement program. Monthly management fees paid to primary care physicians under a primary care case management (PCCM) program are not considered “capitation payments” within the meaning of this section. Such payments, however, should be considered as claims for the purpose of measuring FFS claims payment accuracy.

The “universe” is the set of payments for which the error rate is inferred from the sample. The Medicaid capitated payments universe, from which the sample is to be drawn, consists of those payments described in sections B and C below, *paid* to HMOs or providers for which there is FFP.

The “universe” for the children’s insurance program authorized under Title XXI, for both Medicaid expansions and separate SCHIP programs where there is FFP, is analogous when the program is a capitated managed care program. If the separate SCHIP program is a full-risk indemnity insurance program in which the state pays premiums on behalf of individual

⁹ If there are two or more FFS programs for which the PERM model was applied, please provide both the individual rates and the combined (weighted) accuracy rates.

beneficiaries, substitute “premium payment” for “capitation payment” in the methodology below.

2. *Sample Size and Time Period for Sampling*

The sample size for managed care shall be up to 150 capitation payment claims. If there is also a FFS component of the state Medicaid or SCHIP program, the total of 150 claims or line items shall be proportionally divided between managed care and FFS based on the share of dollar value of the two components in the program. That is, if managed care constituted one-third of all dollar expenditures in Medicaid or SCHIP, while FFS constituted two-thirds, 50 claims would be sampled from managed care and 100 from fee-for-service, as described in the previous section regarding the FFS sample.

The sample shall be drawn from a universe of all capitation payments paid over the first quarter of the Federal FY. Therefore, all claims for which payment was made between, October 1, 2004 and December 31, 2004, inclusive, will be included in the universe for sampling purposes. States will sample 50 submitted capitation payments each month for October, November, and December.

Transactions involving monthly capitation payments made on behalf of beneficiaries enrolled in health plans should be sampled directly, as described in Section B. Transactions involving FFS claims that are paid on behalf of beneficiaries who are enrolled in capitated managed care will be assessed as described in Section C below.¹⁰

B. *Capitated Premium Payments*

1. *Sampling of Capitation “Claims”*

States should treat a claim for a capitation payment made on behalf of an individual beneficiary for an individual month as a “line item” sampling unit for payment error measurement. Capitation payments actually paid by the state or capitation payments submitted for payment but denied by the state should be sampled. If the state has health plan based enrollment, the capitation line items presented on rosters (or other media) by health plans to the states that were not actually paid during the sampling period because the state denied them should be included in the sampling frame.

2. *Audit and Review of Capitation Claims*

Determinations regarding the accuracy of capitation payments made by states require discrete examination of two issues. First, reviewers must determine whether a capitation payment by the state to a specific health plan on behalf of an individual beneficiary for a given month was, in fact, warranted under the rules of the state’s managed care program. Second, in the event that a payment by the state to the health plan for that beneficiary is determined to be appropriate, reviewers must determine whether the proper amount of payment was actually made. The requirements for making both sorts of determinations are described in the following subsections.

¹⁰ This applies, also, to SCHIP programs if there is also a FFS counterpart.

3. *Appropriateness of Capitation Payment*

For each capitation claim drawn for payment error review, reviewers must obtain information from the state's original managed care eligibility and enrollment transaction records that is sufficient to determine whether payment should have been made by the state to that specific health plan on behalf of that specific beneficiary for that specific month. While the exact criteria under which proper enrollment are determined will require assessment of state-specific rules governing such transactions, the critical questions are:

- Was that specific beneficiary eligible for Medicaid or SCHIP (as appropriate) in that month (for sub-sample)?
- Was that specific beneficiary eligible to be enrolled in *any* capitated managed care arrangement in that month?¹¹
- Was the beneficiary eligible to be enrolled in that specific health plan in that month?¹²
- Was the beneficiary actually enrolled in the health plan for that month, and eligible to receive services?¹³

Reviewers should analyze the information available from eligibility and managed care enrollment transaction records and make an independent determination of whether that enrollee was eligible to be enrolled, and actually enrolled, in a specific health plan in the month in question.¹⁴ If that determination confirms the appropriateness of the beneficiary's enrollment in that plan in that month, further assessment of the capitation payment amount should be conducted under the procedure described in the following section. If the eligibility and enrollment determination made by reviewers contradicts the appropriateness of payment to that plan for that beneficiary for that month, the full amount of that monthly capitation payment should be determined to be an inaccurate payment.¹⁵

The managed care review should include a review of the beneficiary eligibility in the month the capitation payment was made for the selected sub-sample of 50 beneficiaries in each program. If the state will be applying the PERM model to both its FFS and its managed care programs within Medicaid, the number sampled from each should be proportional to the dollar value in each component. Similarly, if the state applies the model to more than one SCHIP program, a total of at least 50 SCHIP beneficiaries should be sampled, and distributed evenly across the SCHIP

¹¹ In some states, eligibility for managed care enrollment can vary depending on the place of residence or eligibility status of the beneficiary.

¹² In some states, eligibility for enrollments in specific health plans may be restricted to a subset of the population eligible for enrollment in other health plans.

¹³ Issues involved in assessing actual enrollment include the issuance of a membership card, and whether the beneficiary was enrolled with a specific primary care provider to deliver or authorize care.

¹⁴ See the description of eligibility review in the CMS PERM Model for FFS for more description of the requirements for the review of beneficiary Medicaid eligibility.

¹⁵ The determination of whether any payment is appropriate should turn on actual enrollment in a plan, even if that enrollment resulted from an administrative error that prevented an eligible beneficiary from being enrolled in some other plan of their choice.

programs included. The methods for validation of eligibility are also as described in the FFS discussion.

4. Accuracy of Payment for Properly-Enrolled Beneficiaries

For each capitation payment that is determined under the procedure described above to have been made for a beneficiary who is properly enrolled in that plan for that month, reviewers should make a determination regarding the appropriate amount of payment that should have been made on that beneficiary's behalf. Employing the managed care eligibility and enrollment information gathered in making the determination of appropriate enrollment, reviewers should make an independent determination of the specific capitation payment rate cell that should have been applied to that beneficiary's enrollment with that plan in that month, and the dollar amount that was appropriate for that rate cell.¹⁶ If the state's capitation plan includes variation in payment based on medical or other criteria, the review should attempt to verify that the beneficiary has met the criteria. If the payment system is based on clinical criteria, the reviewer should have sufficient clinical background to make this determination. The amount determined to be the accurate payment amount should be compared to the amount of the actual payment recorded in the sampled transaction record. The amount of any difference between the determined amount and the actual amount should be recorded as an inaccurate payment.

C. Payment of FFS Claims for Managed Care Enrollees

States reviewing the accuracy of monthly capitation payments are also required to assess whether any FFS claims were paid on behalf of beneficiaries during their period of enrollment in a capitated health plan, and whether such payments were accurate.

Concerns about the appropriateness of FFS payments arise when a FFS claim is submitted for services that fall within the scope of services required, under the terms of the state's contract with a capitated plan, to be paid by the capitated plan. In addition to claims for services falling within the scope of full- or partially-capitated arrangements for general medical/surgical services, states may also have capitated arrangements with other benefits managers, (e.g., capitated behavioral health contractors). The payment error rate measurement process must assess the accuracy with which state systems prevent duplicate payments by denying FFS claims for services that fall within the scope of services required to be covered by capitated contractors. If a service falls within the scope of services covered under a capitated contract, a FFS claim payment should be determined to be inappropriate even if the capitated contractor has denied a claim for that service.

(The FFS claims that were erroneously paid to managed care enrollees are based on the capitation managed care sample. Hence, any inferences regarding the total errors made for the universe must be made based on an inference from the managed care side. It would be incorrect to simply include them as errors in the FFS error rate. On the other hand, any dollars in error from this source are FFS dollars, not managed care capitation payments. Hence, the state is required to determine if FFS claims were erroneously paid for recipients in the managed care

¹⁶ If a state's payment methodology involves multiplying a base rate times a series of scalar factors to determine appropriate payment amounts, the term "rate cell" should be interpreted to include distinct premium amounts that result from the application of such factors.

sample who were validly enrolled in a managed care plan. However, it should report the number and dollar value of any such errors separately.)

1. Determination of Claims for Review

The state is required to evaluate FFS claims paid for services incurred during the month of enrollment for each enrollee determined, in the review conducted under Section B above, to be eligible for Medicaid or SCHIP (as appropriate) and properly enrolled in a health plan for that month.¹⁷ Reviewers should obtain, from the state's paid claims history, all of the FFS paid claims for services incurred on behalf of that beneficiary during the enrollment month.¹⁸

2. Determination Regarding Duplication of Coverage

Each FFS claim for a service that is determined to have been incurred during the period in which a beneficiary was actually enrolled in a capitated managed care organization should be reviewed for appropriateness of FFS payment in light of the terms of the contract with the specific managed care organization in which the beneficiary was properly enrolled. This determination should be made with regard to the explicit language of the contract between the state and that health plan, read together with any clarifying or interpretive documents available.

Where a determination regarding contractual coverage turns on clinical issues, that determination should be made in light of the findings of the medical record audit and review process described in the FFS model. If the review supports a determination that the claim was, in fact, covered within the scope of a capitated managed care contract with a managed care organization with which the beneficiary was actually enrolled, the full amount of the paid claim should be reported as an inaccurate payment.

3. Special Instructions Regarding Capitated Non-Enrollment Options

If a state makes capitated payments to managed care contractors on a population-wide basis without regard to the enrollment of individual beneficiaries, the state should follow these special instructions for additional review of claims sampled in the FFS claims payment error measurement process described in the FFS model. For the purposes of this section, a "capitated non-enrollment option" is defined as a program under which a state makes a capitation payment to a managed care vendor to furnish a specified scope of services, such as behavioral health services, to all beneficiaries falling within a particular class, without requiring individuals to actively enroll with the contractor to receive services.¹⁹ Enrollment in full-risk HMOs would therefore not be included in this definition. The purpose of this review is to determine, in a manner analogous to the review described above, whether any FFS claims have been paid that should have been denied by reason of their coverage under the scope of work of the managed care contractor.

¹⁷ Reviews of claims that may be covered by capitation arrangements that do not involve enrollment are discussed in subsection C.3.

¹⁸ The state should review all paid claims for services incurred during this period, even if the claim was not paid until after the end of the period in which paid claims were sampled in the FFS model.

¹⁹ While such program options may commonly "enroll" beneficiaries in their case management programs once individuals are identified as needing such services, they would still be considered "non-enrollment options" as long as the capitation payments are made without regard to such "enrollments."

In preparing for the payment error rate measurement program, reviewers should analyze the contract(s) between the state and any such contractor(s), and make a determination regarding the classes of claims that are clearly excluded from payment by the contractor(s) under the terms of the contract(s) in all relevant periods.²⁰

As part of the review of FFS claims sampled under the FFS model, reviewers should determine whether that sample contains claims that fall within classes of services not explicitly excluded from payment under the terms of the capitated non-enrollment program. Each claim for a service that is determined not to be explicitly excluded from coverage under the state's capitated non-enrollment program(s) should be reviewed to determine whether that claim should have been paid by a contractor. If it is determined that a claim should not have been paid by the FFS claims processing system, the full amount of the claim should be reported as an inaccurate payment under the FFS model.

D. Computation of the Payment Error Rate for Capitated Managed Care

1. Capitated Payments

We ask that states identify the payment errors and the dollar value of the FFS payments made in error for services provided during the period for which the beneficiary was covered under a managed care agreement. However, these errors should be reported separately and not included in the calculation of the state-level error. (Formulas to calculate the state level error rates are provided in Appendix C.) CMS will calculate a payment error rate at the national level.

If a state wishes to review a larger sample in order to calculate a state-level payment error rate within a reasonable level of precision, CMS can provide assistance in calculating the state-level rate.

E. Reporting

The following information for the managed care samples should be provided in the final report:

- the payment error rate;
- its standard error and 95 percent confidence interval;
- total sample size of the universe, measured by both number of items and dollar value;
- proportion of dollars and proportion of items represented by the universe in the sample;
- dollar distribution of errors by over and under payments and by the following reasons:
 - ineligible beneficiary
 - incorrect payment amount

²⁰ For this purpose, the “relevant period” is date of service for those line items sampled in the FFS sample. The key issue is whether the beneficiary should have received the service under the (non-enrollment) managed care agreement, rather than on a FFS basis.

- projected estimates of total over- and under-payments for capitation payments for the period of inference.
- FFS payments made in error-projected estimates of total over and under payments for the period of inference; and
- findings and observations resulting from the analysis.

II. AWARD INFORMATION

A. Funding

CMS has approximately \$2.5 million in HCFAC funds to reimburse the state share of the costs of participation for twenty-five or more states. Because the sample sizes in the PERM pilot will be considerably smaller than in previous years, we anticipate project costs will be substantially less. Therefore, to ensure that we have adequate funding for 25 or more states, we are asking states to limit their request for HCFAC grant funding to \$100,000 and to make sure that their total costs do not exceed \$200,000. States that submit applications with budgets in excess of these limits will be considered only as funding permits. State participation in the PERM pilot will be 100 percent Federally funded through a combination of FFP and HCFAC grant funding as reimbursement for what would otherwise be the state share.

If a state has participated in a past project, is currently participating in a project, or has had never participated in a project, the state is eligible to compete for new awards.

The authority for this project is provided for under section 402(a)(1)(J) of the Social Security Act Amendments of 1967. States will report project costs up to the approved funding ceiling on the Notification of Grant Award on their quarterly Medicaid and SCHIP expenditure reports (Form CMS – 64.10 Waiver and Form CMS – 21 Waiver) at the applicable match rate, and receive the Federal share through the standard grant award and draw down process. The HCFAC special grant funds will be paid through a separate draw down account established in the Payment Management System (PMS) for that purpose. The use of these two funding mechanisms ensures that states will receive 100 percent Federal reimbursement for all PERM Project costs. The detailed financial proposal accompanying the application must demonstrate an understanding of the funding mechanism.

CMS will announce the awards by September 30, 2004. Applications are due no later than 45 calendar days from the date of this solicitation. The funding is for the period of September 30, 2004 through September 29, 2005.

III. Eligibility Information

1. Eligible Applicants

Applications for the PERM pilot will be accepted from three types of agencies: 1) the state Medicaid agency; 2) the state agency that administers SCHIP; or 3) the State Auditor, Comptroller or other state agency, in partnership with the state Medicaid agency. Participation is open to all states and the District of Columbia, regardless of participation in prior years of the payment accuracy measurement demonstration project. States that participated in previous years

are encouraged to submit an application to participate in the PERM pilot; however, priority will be given to states that have not previously participated. The territories will be excluded from participation in the FY2005 PERM pilot test.

2. Cost Sharing or Matching

State participation in the PERM pilot will be 100 percent Federally funded through a combination of FFP and HCFAC grant funding as reimbursement for what would otherwise be the state share. Therefore, no cost sharing or matching is required.

IV. Application and Submission Information

1. Address to Request Application Package

The application kit can be accessed electronically at:
www.cms.hhs.gov/researchers/priorities/grants.asp

2. Content and Form of Application

Format of the Application

Each application must include all contents described below, in the order indicated, and in conformance with the following specifications:

Use white paper only.

Use 8.5" x 11" pages (on one side only) with one-inch margins (top, bottom, and sides). Paper sizes other than 8.5" x 11" will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5" x 11".

Use a font not smaller than 12-point.

No more than 12 pages for the narrative responses. Other forms and documents required as part of the grant application do not count toward the page limit.

Additional documentation may be appended; however, material should be limited to information relevant but not essential to the specific scope and purpose of the grant.

Do not bind copies. Secure pages with a binder clip, paper clip, or 3-ring binder.

Required contents

A complete proposal consists of the following: an understanding of the problem, technical approach, management plan, and budget. These criteria are further defined in the Application Review Criteria section below. A total of 100 points may be awarded for the required questions.

3. Submission Dates and Times

Applications are due no later than 45 calendar days from the date of the solicitation. Applications mailed through the U.S. Postal Services or a commercial delivery service will be considered on time if they are received in the CMS Grants Office or postmarked by the closing date. Submissions by facsimile (fax) transmission will not be accepted. A proposal not postmarked by the closing date will be considered late. Late proposals will not be considered and will be returned without review.

An original proposal should be sent with two copies to:

Centers for Medicare & Medicaid Services
OICS, Acquisition and Grants Group
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attn: Linda Bianco
Email: lbianco@cms.hhs.gov
Phone: (410) 786-7080

4. Intergovernmental Review

Executive Order 12372 or “Intergovernmental Review of Federal Programs” (45 CFR Part 100) is not applicable to this program.

5. Funding Restrictions

Funds may be used for payment of direct expenses associated with the project. The government or other organizations or entities may expend the funds with the responsibility to perform the activities requested under the agreement. Examples of these direct expenses may include but are not limited to: designing and drawing the statistical sample, contractor-related expenses for auditing medical records, and the cost of retrieving records from various locations.

Funds under this initiative may not be used for services or consultants whose purpose is not related to this demonstration project. Funds may not be used for equipment purchase or overhead costs. The indirect costs may not exceed 9 percent.

6. Other Submission Requirements

Dun and Bradstreet Number

Beginning October 1, 2003, applicants are required to have a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in the block with the applicant’s name and address on the cover page of the

1. Staffing/Contracting Approach

20 of 40 Points

The proposed demonstration project must be staffed by persons with the experience and skills necessary to conduct and participate in a Medicaid and SCHIP payment error measurement study. States should coordinate internally among Medicaid and SCHIP programs if necessary. States may also choose to contract with external organizations to conduct parts of the review (e.g., create the data extract and sample, conduct medical record review). The respondent should provide:

1. A description of how the project will be staffed and how staff will be organized. If relevant, describe how Medicaid and SCHIP PERM models will be coordinated within the state. Please indicate the expected number of persons that will be assigned to the project and the estimated amount of time that will be spent on each aspect of the project (expressed on a full-time-equivalent basis).
2. A summary of the scope of work for any aspects of the project to be contracted out (if the state plans to use contractors). Indicate whether the vendor has been selected (or, if not, the timeline for contracting), and describe the process for contract oversight.
3. A discussion of quality control within the demonstration project, including methods to ensure the sample is drawn appropriately and that adequate structures are in place to promote consistency and accuracy in medical review.

2. Project Timeline and Level of Effort 20 of 40 points

The state should present a timeline for the year-long study to begin October 1, 2004. The timeline should be consistent with sampling claims that were submitted in the period October 1 to December 31, 2004, and producing preliminary findings in the period April 1 to June 30, 2005, if possible. The state will provide quarterly progress reports 30 calendar days after the end of the each quarter (i.e., by January 31, April 30, and July 31, 2005), and a final report no later than 30 calendar days after the end of the fourth quarter (i.e., by October 31, 2005). In addition, the state should plan for one 2-day conference in the Baltimore/Washington D.C. area, midway through the project year.

The timeline should indicate (by month or by quarter):

1. Major activities, milestones, and deliverables (including all activities listed above).
2. How the staffing effort is allocated over the timeline.

D. Budget

The project budget will not be scored on a point system. Costs will be evaluated relative to the technical merits of the proposal. The CMS goal of the project is to attempt to fund at least 25 applications. Because the total budget for the project is constrained, costs for individual proposals will also be evaluated based upon achieving this goal. Using Budget Form SF-424A, provide an estimate of the aggregate expenditures expected to support the project approach and level of effort described above.

In the narrative section of your proposal, please delineate the costs associated with the core requirements of the CMS PERM model, including a summary that separately identifies costs for FFS and managed care (if relevant) and for Medicaid and SCHIP. Shared costs may be noted. Also, if your proposed sample size exceeds 150 for either of the programs, or if the eligibility sub sample exceeds 50 for either of the programs, please separately indicate the additional costs associated with the excess sample. The sum of the program budgets described in this narrative (e.g., Medicaid FFS, Medicaid managed care, SCHIP FFS, SCHIP managed care) should equal the amount noted on Budget Form SF-424A.

2. Review and Selection Process

A panel of experts will conduct an objective review of all applications. The panelists will assess each application based on the review criteria to determine the merits of the proposal and the extent to which the state evidences the capacity to implement the PERM pilot.

CMS will make final award decisions based on consideration of the comments and recommendations of the review panelists and the availability of funds.

All award recipients under this agreement must meet the requirements of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; the Discrimination Act of 1975; and provisions of Title II, Subtitle A of the Americans with Disabilities Act of 1990.

3. Anticipated Announcement and Award Dates

CMS will announce the awards by September 30, 2004. Grantees will receive award letters, terms and conditions, and notices of grant award at that time.

VI. Award Administration Information

1. Award Notices

Grant awards will be issued within the constraints of available Federal funds and at the discretion of CMS. The official award document is the "Notice of Grant Award (NGA)." It will provide the amount of the award, purpose of the award, terms of the agreement, duration of the project period for which funding is available, and any special terms and conditions of the grant. Once signed by the awarding office, the NGA package will be mailed directly to the authorized official as indicated on the SF 424 face page.

2. Administrative and National Policy Requirements

General Terms and Conditions for these grants are available for reference on our website at <http://www.cms.hhs.gov/agg>. In addition to General Terms and Conditions, applicants should be aware that they may be required to comply with Special Terms and Conditions, which will, at a minimum, include participating on scheduled PERM pilot conference calls and attending one PERM pilot conference. We anticipate that the will be held in the Baltimore/Washington area. The special terms and conditions are used to clarify particular grant activities and assure that grant funding is being used in a permissible manner. Because these terms and conditions are

written specific to a particular grant, it is not possible to review them prior to application submission.

States receiving awards must agree to cooperate with any evaluation of the product of the work and to provide required information and reports in a format prescribed by CMS.

3. Reporting

States shall submit quarterly progress reports that are due 30 days after the end of the quarter. In addition, the Financial Status Report (SF-269a) will be due on an annual basis. States shall also submit a final project report due 30 days after the end of the project; the final report may be submitted in lieu of the fourth quarter report. The reporting requirements for the final reports are specified below.

Medicaid and SCHIP Fee-For-Service Reporting Requirements:

The following information for the FFS samples should be provided in the final report:

- the payment error rate;²¹
- its standard error and 95 percent confidence interval;
- point estimates of rate by stratum (if applicable);
- total sample size of the universe, measured by both number of items and dollar value;
- proportion of dollars and proportion of items represented by the universe in the sample;
- total sample size and sample size of each stratum (if applicable), measured by both number of items and dollar value;
- proportion of dollars and proportion of items represented by each stratum (if applicable), both in the universe and in the sample;
- dollar distribution of errors by reason and by over-payments versus under-payments;
- projected estimate of total over- and under-payments for the period of inference; and
- findings and observations resulting from the analysis.

Medicaid and SCHIP Managed Care Reporting Requirements:

The following information for the managed care samples should be provided in the final report:

- the payment error rate;
- its standard error and 95 percent confidence interval;
- total sample size of the universe, measured by both number of items and dollar value;
- proportion of dollars and proportion of items represented by the universe in the sample;

²¹ If there are two or more FFS programs for which the PERM model was applied, please provide both the individual rates and the combined (weighted) accuracy rates.

- dollar distribution of errors by over and under payments and by the following reasons:
 - ineligible beneficiary
 - incorrect payment amount
- projected estimates of total over- and under-payments for capitation payments for the period of inference.
- FFS payments made in error-projected estimates of total over and under payments for the period of inference; and
- findings and observations resulting from the analysis.

VII. Agency Contacts

Questions regarding grants administration should be submitted to:

Centers for Medicare & Medicaid Services
OICS, Acquisition and Grants Group
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attn: Linda Bianco
Email: lbianco@cms.hhs.gov
Phone: (410) 786-7080

Questions regarding Payment Error Rate Measurement (PERM) content should be directed to:

Payment Error Rate Measurement (PERM) Pilot
Office of Financial Management
Mail Stop C3-02-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attn: Christine Saxonis
Email: csaxonis@cms.hhs.gov
Phone: (410) 786-3722

VIII. Other Information

APPENDIX A
STRATA DEFINITIONS FOR SAMPLING SERVICES

Stratum 1: Hospital Services

- Inpatient hospital services

Stratum 2: Long-Term Care Services

- Nursing facility services
- Inpatient psychiatric facility services for individuals 21 and under
- Other mental health facility services for individuals 65 or older
- ICF/MR services
- Religious non-medical health care institutions

Stratum 3: Other Individual Practitioners, Clinics

- Outpatient hospital services
- Clinic services
- Physician services
- Other licensed practitioner services
- Physical/occupational/speech therapy, etc.
- Rehabilitative services
- Dental services
- Nurse midwife/nurse practitioner

Stratum 4: Prescription Drugs

- Separately billed prescribed drugs

Stratum 5: Home and Community-Based Services

- Home health services
- Private duty nursing
- Personal care services
- Hospice services
- Targeted case management services

Stratum 6: Other Services and Supplies

- Lab and X-ray services
- Transportation
- Other services
- Sterilization services
- Abortions
- Unknown

Stratum 7: Fixed Payments on Behalf of Individual Beneficiaries (if applicable)

- Primary care case management payments
- Medicare Part A and Part B premiums

APPENDIX B

PAYMENT ERROR RATE MEASUREMENT MEDICAL REVIEW GUIDELINES

This document provides general guidelines for medical review for the Payment Error Rate Measurement types of services i.e., Inpatient Services, Long-Term Care Services, and Other Individual Practitioners and Clinics. The goals and processes apply to all areas and the medical review steps are delineated for each type of service. These guidelines were developed to provide a basic framework across all states for the medical review process. They should not replace your state guidelines if there are discrepancies.

1.0 Goals of Payment Error Rate Measurement Medical Review

1. Identify inappropriate billing in an effort to improve the payment accuracy and decrease the receipt of bills for unnecessary services;
2. Assure that payment is made only for covered items and services as described in State Medicaid or SCHIP Guidelines;
3. Assure that services do not exceed the patient's medical needs; and
4. If fraudulent behavior is found, comply with fraud and abuse guidelines for referral to the appropriate area.

2.0 Recommended Medical Review Steps

1. At the beginning of the medical review process, existing policies and guidelines are researched. The reviewer should be familiar with:
 - Medicaid State Policy Manual
 - Data Analysis Statistics for the provider
 - Medical Necessity Criteria
 - Applicable Coding Rules
 - Literature searches
2. Claims and the medical records are reviewed and analyzed by a Registered Nurse.
3. Nurses review the medical records and determine medical necessity, reasonableness of the paid services under review, and appropriateness of the clinical setting.
4. Determinations are made based on State Rules and Regulations.
5. During the medical review process, if the provider fails to submit the requested documentation within the prescribed time frame, deny the claim and/or adjust the claim accordingly. If the provider furnishes documentation that is incomplete (insufficient to support medical necessity), adjust the claim in accordance with your State Payment Policy.
6. If payment errors are identified, an educational letter is prepared for the facility. It is recommended the educational letter should contain:
 - Specific case examples and errors identified;

- Policy and guideline references and explanation;
- Cite medical necessity, documentation, and coding issues in the letter as indicated;
- The overpayment amount; and
- Copies of the actual policies and guidelines.

3.0 Specific Medical Review Guidelines by Type of Service:

3.1 *Inpatient*

Inpatient claims and the medical records are reviewed and analyzed by a Registered Nurse.

1. Nurses review the medical records and determine medical necessity and reasonableness of the paid services under review.
2. Determinations are made for:
 - ♦ Appropriateness of admission;
 - ♦ Continued stay review;
 - ♦ Appropriateness of acute setting; and
 - ♦ Appropriateness and accuracy of ICD-9-CM coding.
3. Determinations are made based on State Rules and Regulations and medical necessity criteria

3.2 *Long-Term Care Services*

Long Term Care Service claims and the medical records are reviewed and analyzed by a Registered Nurse. Nurses review the medical records and determine medical necessity and reasonableness of the paid services under review. Determinations are made for:

1. Appropriateness of admission;
2. Continued stay review;
3. Level of care; and
4. RUGS-III codes if applicable.

Determinations are made based on State Rules and Regulations and other sources submitted such as the Minimum Data Set (MDS).

3.3 *Other Individual Practitioners and Clinics*

Claims and the medical records are reviewed and analyzed by a Registered Nurse. Nurses review the medical records and determine the medical necessity and reasonableness of the paid services under review. Determinations are made for:

1. Medical record documentation substantiation of the services paid.
2. Medical necessity of the service is appropriate.

3. Appropriateness and accuracy of ICD-9-CM diagnosis coding and CPT procedure coding, and diagnosis supports the procedure code.

Note: Date discrepancies off by one or two days with medical record substantiation of services performed should be noted and not counted as a payment error.

3.4 Dental Services

Claims and medical records are reviewed and analyzed by a Registered Nurse or Dental Hygienist to determine the medical necessity and reasonableness of the paid dental services under review. Determinations are made for:

1. Presence of documentation to substantiate that the dental provider was a qualified Medicaid provider;
2. Presence of documentation to substantiate that the dental services billed were actually delivered;
3. Appropriateness and accuracy of coding/billing;
4. Presence of medical record documentation to substantiate that based on the patient's age, medical/dental condition and/or symptoms the dental services were medically necessary (e.g., sealants for children not adults, oral surgery procedures); and
5. Verification that the dental service, as provided, was in compliance with the state's coverage policies, should have been paid under the FFS program, and was not the responsibility of an MCO if applicable.

3.5 Pharmacy

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine the medical necessity and reasonableness of the paid pharmacy services under review.

Determinations are made for:

1. Presence of documentation to substantiate that the drug was prescribed by a licensed provider;
2. Presence of documentation to substantiate that the prescription was filled (including ordered dosage and number or amount of drug) by the pharmacy;
3. Appropriateness and accuracy of NDC and/or local coding conventions utilized for billing;
4. Presence of medical record documentation that substantiates that diagnosis and medical necessity are present to support use of the prescribed drug; and
5. Verification that the drug should have been paid for by the FFS program and was not the responsibility of an MCO.

3.6 Home Health and Community Services

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine the medical necessity and reasonableness of the paid home health or community services under review. Determinations are made for:

1. Presence of documentation to substantiate that the service was prescribed by a qualifying Medicaid/SCHIP provider;
2. Presence of documentation to substantiate that the service provider was a qualified Medicaid/SCHIP provider;
3. Presence of documentation to substantiate that the service was actually delivered/provided to the patient in the amount billed (this may require telephonic contact with the member);
4. Appropriateness and accuracy of coding/billing;
5. Presence of medical record documentation to substantiate that based on the patient's diagnosis/medical condition and/or symptoms the service was medically necessary; and
6. Verification that the service, as provided, was in compliance with the state's coverage policies, should have been paid under the FFS program, and was not the responsibility of an MCO if applicable.

3.7 Durable Medical Equipment (*note: these may fall into Stratum 5 or 6*)

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine the medical necessity and reasonableness of the paid DME services under review. Determinations are made for:

1. Presence of documentation to substantiate that the DME was prescribed by a qualifying Medicaid provider;
2. Presence of documentation to substantiate that the DME provider was a qualified Medicaid provider;
3. Presence of documentation to substantiate that the DME was actually delivered/provided to the patient in the quantity billed (this may require telephonic contact with the member);
4. Appropriateness and accuracy of coding/billing;
5. Presence of medical record documentation to substantiate that based on the patient's diagnosis/medical condition and/or symptoms the DME was medically necessary; and
6. Verification that the DME, as provided, was in compliance with the state's coverage and rent/purchase policies, should have been paid under the FFS program, and was not the responsibility of an MCO if applicable.

3.8 Transportation Services

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine the medical necessity and reasonableness of the paid transportation services under review. Determinations are made for:

1. Presence of documentation to substantiate that the transportation provider was a qualified Medicaid/SCHIP provider;

2. Presence of documentation to substantiate that the transportation service was actually delivered/provided to the patient (this may require telephonic contact with the member);
3. Appropriateness and accuracy of coding/billing (mileage, mode of transport such as van/ambulance/cab/bus, activity level of patient such as ambulatory, wheelchair, bed bound, and appropriate destination);
4. Presence of medical record documentation to substantiate that based on the patient's diagnosis/medical condition and/or symptoms the service was provided at the appropriate level; and
5. Verification that the service, as provided, was in compliance with the state's coverage policies, should have been paid under the FFS program, and was not the responsibility of an MCO if applicable.

3.9 *Managed Care Capitation*

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine if the capitated rate paid to the managed care organization was paid in the correct amount.

Determinations are made regarding:

1. Eligibility and enrollment of the member in the MCO during the time covered by the capitation rate;
2. Documentation to support that the member was assigned to the appropriate capitation rate cell/adjusted risk group if applicable (age/sex/diagnosis); and
3. Capitation rate was paid in accordance with state capitation payment policies.

4.0 *Request for Medical Record Information*

The medical review information for all types of service is requested via a letter, sent by certified mail, to the facility. A time limit should be established for receipt of the medical records. Thirty (30) days is a suggested time frame. The medical record request letter should contain an explanation of the Payment Error Rate Measurement pilot and a listing of the sample. It is recommended the sample listing include:

- The patient's name;
- The patient's Medicaid number;
- The patient's date of birth; and
- The date(s) of service.

The medical record documentation request should specify the description of records, for all that apply to your state, as follows:

4.1 *Inpatient*

- Pre-authorization form if applicable
- Face sheet to include coding for hospital stay

- Complete billing listing of all charges, payments, or adjustments for the hospital stay (Example: Account Ledger/Billing Statements)
- Physician's orders and progress notes
- Operative Reports
- Pathology Reports
- Anesthesia Records including pre and post -op
- Admission History and Physical
- Nurse's Notes
- Medication Records
- All Laboratory and X-ray Reports
- Cardiovascular, Procedure/Reports (EKG, Stress test, Echo etc.)
- All Flow Sheets (including vital sign records)
- Nursing Care Plan and/or Critical Pathways
- Consultation Reports
- Discharge Summary
- Any ER Notes related to the admission
- Hospital Transfer Form (if applicable)
- PT/OT/SLP Progress Notes (including charts for daily therapy, and documentation of therapy minutes)
- Any Additional Documentation that demonstrates the medical necessity of the services or procedures performed
- Name and Telephone Number of the Contact Person for Facility

4.2 *Long Term Care Services*

- Medical Eligibility Request Form
- Signed Minimum Data Set (MDS) – All that apply
- Documentation for look back periods (this may be prior to requested dates of service)
- Physician's orders and progress notes: hospital if applicable and NFS
- History and Physical Reports
- Nurse's notes for the NFS
- Medication sheets
- All flow sheets, including vital sign records and weight charts
- Nursing care plan

- Consultation reports
- Discharge summary
- Hospital transfer form
- PT/OT/SLP Progress Notes, including charts for daily therapy, and documentation of therapy minutes
- All treatment plans and therapeutic goals, including objective and subjective findings to support continuing treatment
- Any additional documentation that demonstrates the medical necessity of the service performed
- List of any abbreviations or symbols used and their meanings
- The name and telephone number of the contact person in your facility

4.3 *Other Individual Providers and Clinics*

- Office notes
- Procedure reports (if applicable)
- Operative reports
- Emergency Room records (if applicable)
- Physician's orders and progress notes (if applicable)
- History and Physical Reports
- Consultation reports
- Discharge summary (if applicable)
- Laboratory reports (if applicable)
- X-ray reports (if applicable)
- Pathology reports (if applicable)
- Nurses' notes
- Nursing home notes (if applicable)
- Cardiovascular, Procedure/Reports (EKG, Stress test, Echo, etc.)
- Treatment plan
- Immunization records
- List of any medications given
- Anesthesia records (including pre- and post-anesthesia)
- Any additional documentation that demonstrates the medical necessity of the services provided

4.4 *Dental*

- Dental claim
- Applicable Medicaid policies for dental coverage
- Medical record from attending dental provider
- Dental x-rays, molds, etc. if applicable
- Prior authorization documentation if applicable

4.5 *Pharmacy*

- Pharmacy claim
- Prescription
- Applicable Medicaid policies for prescription drug coverage to include formulary with NDC codes and MCO coverage policies
- Medical record from prescribing physician if policy or medical necessity question
- Prior authorization documentation if applicable
- Member pharmacy signature log if applicable

4.6 *Home and Community Services*

- Medicaid claim
- Medicaid policies and procedures associated with the provision of home health and community services
- Prior authorization documentation if applicable
- Complete billing listing of all charges, payments, or adjustments for the services (Example: Account Ledger/Billing Statements)
- Member services signature log if applicable
- OASIS data if applicable
- Physician's orders
- History and Physical and/or hospital discharge summary if appropriate
- Intake/initial assessment
- Nurse's Notes (including documentation of nursing time/minutes)
- Nurse's Aid/Personal Care Attendant Notes
- Personal care assistant notes and documentation of time/minutes if applicable
- Medication Records
- All Flow Sheets (including vital sign records)
- Nursing Care Plan/Case Management Plan

- Consultation Reports
- Discharge Summary
- Hospital Transfer Form (if applicable)
- PT/OT/SLP Progress Notes (including charts for daily therapy, and documentation of therapy minutes)
- Respiratory Therapy Progress Notes
- Infusion Therapy Notes
- Dietary/Nutrition Notes
- Any additional documentation that demonstrates the medical necessity of the services provided
- Name and telephone number of the member/contact person for the member
- Name and telephone number of the contact person for home health agency

4.7 *Durable Medical Equipment*

- DME claim/invoice
- Certificate of Medical Necessity
- Applicable Medicaid policies for DME coverage
- Medical record from prescribing physician
- Prior authorization documentation if applicable
- Member DME signature log or signed receipt if applicable

4.8 *Transportation*

- Provider claims corresponding to date of transport
- Transportation claim
- Transportation provider's account ledger/billing statements
- Transportation scheduling log
- Transportation Log with member signature if applicable
- Medical record from provider corresponding to transportation date to verify enrollee's ambulatory status and medical necessity for transportation

4.9 *Managed Care*

- Claims history to verify rate cell diagnoses
- Medical record from PCP/specialist to verify diagnosis/condition is present that placed patient in the capitation rate cell if applicable (e.g. HIV, pregnancy, special needs child)

5.0 PAM ERROR CODES AND HIERARCHY

5.1 *Processing Validation Error Codes*

- P1 - Duplicate item (claim) – an exact duplicate of the claim was paid – same patient, same provider, same date of service, same procedure code, and same modifier.
- P2 - Non-covered service – policies indicate that the service is not payable by Medicaid
- P3 - MCO covered service – the beneficiary is enrolled in a managed care organization that should have covered the service and it was inappropriate to bill Medicaid.
- P4 - Third party liability – inappropriately billed to Medicaid.
- P5 - Pricing error – payment for the service does not correspond with the pricing schedule
- P6 - Logical edit – a system edit was not in place based on policy or a system edit was in place but was not working correctly and the claim line was paid.
- P7 - Ineligible recipient—the recipient was not eligible for the services or supplies.
- P8 - Data entry errors – there were clerical errors in the data entry of the claim.
- P9 - Other – if this category is selected a written explanation is required in the comment section beside the category.

5.2 *Medical Review Error Codes*

- MR1 – No documentation submitted – the line is unsupported due to no response to the documentation request.
- MR2 – Insufficient documentation submitted – the line is unsupported due to insufficient response to documentation request. Information was submitted by the provider, but it either was for the wrong date of service or did not support the procedure code billed.
- MR3 – Coding error – the procedure was performed but billed using an incorrect procedure code.
- MR4 – Unbundling – billing components of procedure codes when only one procedure code is appropriate.
- MR5 – Medically unnecessary service – medical review indicates that the service is medically unnecessary based upon the documentation of the patient’s condition in the medical record.
- MR6 – Administrative error – medical review indicates an administrative error, such as an incorrect decision on a previous medical review or other administrative errors as designated by the state. This error may or may not result in a payment error.

- MR7 – Policy violation – a policy is in place regarding the service or procedure performed and medical review indicates that the service or procedure is not in agreement with the documented policy. An inappropriate diagnosis for a service or procedure, as documented in the policy, would also fall into this error code.
- MR8 – Other - if this category is selected a written explanation is required in the comment section beside the category.

If there is more than one error within the processing or medical review components, dollars should be allocated to the errors to reflect the dollars reduced or denied for the claim, in the order in which the errors are discovered. For example, if the claim or line items is denied 100 per cent for processing reasons, there would be no requirement to request documentation for medical review of the claim or line item.

APPENDIX C PAYMENT ERROR RATE CALCULATION

Computation of the Payment Error Rate for Fee-for-Service Claims

The payment error rate can be computed in two ways. In both methods, the estimate is based on the gross total of overpayments and underpayments, as required by the Improper Payments Information Act of 2002.

The first method is a ratio estimate. In this method, the numerator of the ratio consists of the sum of the dollar value of errors. Errors include both overpayments and underpayments. They do not offset. If there is a \$10 overpayment error and a \$5 underpayment error, the total errors entered in the numerator is \$15. The denominator of the ratio is the total dollar value of sampled line items paid. If, upon review, the payment of a line item is reduced, but not fully denied, the amount of the reduction appears in the numerator as an error. If, upon review, the payment of a line item is increased, the amount of the increase appears in the numerator as an error. For example, if there were \$100 of paid line items sampled, and it was found that there were \$10 in overpayments and \$5 in underpayments, the accuracy rate would be 15 percent or $(\$10+\$5)/\$100$. Overpayments and underpayments do not “offset” each other, but combine into a total payment error.²²

The accuracy rate, when there are K sampling strata, is given by:

$$AccuracyRate = \frac{\sum_{j=1}^K \sum_{i=1}^{N_j} w_j (o_{i,j} + u_{i,j})}{\sum_{j=1}^K \sum_{i=1}^{N_j} w_j P_{i,j}^M}$$

where $P_{i,j}^M$ is the dollar amount of the i^{th} paid line item in stratum j that was paid to a provider for the i^{th} line item in stratum j and “o” represents any overpayment while “u” represents an underpayment. The W_j ’s are the relevant weights for the strata applied to the items to account for over- and under-sampling. These weights, for each stratum, will be the ratio of the proportion of line items in the universe in that stratum to the proportion of line items in the sample represented by that stratum. The sample size is N, overall, with N_j line items in stratum j .

Under the alternative method, a difference estimate, we define F as the proportion of all the claims or line items submitted in the period that are represented by the sample. For example, if 1 percent of all claims in the period were sampled, then $F=.01$. The estimated total dollar amount of accurate payments is given by the expression:

²² This is in accordance with the Improper Payments Information Act (P.L. 107-300) and implementing OMB guidance.

$$TotalEstimatedErrors = \frac{\sum_{j=1}^K \sum_{i=1}^{N_j} w_j (o_{i,j} + u_{i,j})}{F}$$

Then, the accuracy rate is equal to:

$$ErrorRate = \frac{TotalEstimatedErrors}{TotalPayments}$$

Under both methods of estimation, the concept of the error rate is the same:

$$ErrorRate = \frac{\{overpayments + underpayments\}}{ActualPayments}$$

The estimation of the error rate for the SCHIP samples is similar, except that there are no strata. That is, the estimate would be modified as:

$$AccuracyRate = \frac{\sum_{i=1}^N (o_i + u_i)}{\sum_{i=1}^N P_i^M}$$

where N is the sample size. A similar modification would apply to the difference estimate.

An analytical estimate of the standard error for the ratio estimator can only be approximated. We recommend bootstrapping or related re-sampling techniques for estimating the standard error for the ratio estimate. An estimate of the standard error using the alternative method is straightforward, analytically.

Computation of the Payment Error Rate for Capitated Managed Care

The CMS PERM Model for capitated managed care should be estimated in a manner analogous to the FFS accuracy rate described in the previous section. The denominator should include the dollar value of all the capitation payments made in the sample. The numerator should include the dollar value of the errors, including both overpayments and underpayments using equations similar to those for the FFS model, but without strata.

In addition, the review may reveal that FFS payments were made in error for some sampled beneficiaries covered under capitated managed care agreements. If so, the dollar value of the FFS payments made in error for services provided during the period for which the beneficiary

was covered under a managed care agreement should be reported separately, and not be included directly in the accuracy rate.

Computation of a Payment Error Rate for Multiple SCHIP FFS Components

If the state were to estimate accuracy rates for two or more SCHIP FFS components (because, for example, the state had both a stand alone SCHIP FFS program and a FFS SCHIP program that was part of a Medicaid expansion), it should estimate an overall SCHIP error rate as the weighted average of the separate rates. The weights should represent the proportions or shares of total dollar value of the FFS SCHIP program represented by each component. For example, if the Medicaid expansion represented 40 percent of the total dollar value of the FFS SCHIP in the state, and a separate SCHIP FFS program represents 60 percent, then the overall SCHIP FFS accuracy rate would be obtained as the combination of the two:

$$SCHIP_{Fee-for-Service}Rate = .4 * ExpansionRate + .6 * separateSCHIP$$

Computation of a Combined Payment Error Rate for FFS and Managed Care

States that apply the PERM model to both FFS and managed care Medicaid programs should combine the results of the FFS accuracy rate analysis and managed care accuracy rate analysis into one combined Medicaid rate. One can do this using either the “ratio” method or the “difference” method discussed above. Under the ratio method, the combined Medicaid rate is a weighted average of the FFS and managed care rates:

$$CombinedMedicaidRate = w_{ffs} * MedicaidFFSErrorate + w_{mc} * MedicaidMCErrorate$$

where the weights, “w”, are the shares to total payments for the FFS program and managed care program, respectively.

Using the “difference” method, the calculation would be:

$$CombinedMedicaidRate = \frac{TotalEstimatedFFSErrors + TotalEstimatedMCErrors}{TotalFFSPayments + TotalMCPayments}$$

The same formulas can be used to develop a combined payment accuracy rate for FFS and managed care components of an SCHIP program; substitute SCHIP payments and errors for Medicaid payments and errors in the above formulas.