COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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January 10, 2014

MEMORANDUM

TO: The Honorable Robert F. McDonnell
Governor of Virginia

The Honorable Walter A. Stosch
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones Cynthia Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on the Results of the Payment Error Rate Measurement (PERM) Review

The 2013 Appropriation Act, Item 310 G states:

> *The Department of Medical Assistance Services shall report on the results of the federally-required review in the Payment Error Rate Measurement program for federal fiscal year 2012. This report shall include the error rates for both claims and eligibility determinations. If locality specific error rates for the eligibility review are available, they should be included in the report. The department shall report the findings to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2013.*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Department of Medical Assistance Services
Annual Report to the General Assembly

Report on Results of the Payment Error Rate Measurement (PERM) Review

December 2013

Report Mandate

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Background

The federal government conducts the Payment Error Rate Measurement (PERM) review once every three years in each state to measure improper payments in state Medicaid programs. The Children's Health Insurance Program (CHIP), which is also administered by the Department of Medical Assistance Services (DMAS), was evaluated for the first time in the FFY2012 cycle. The findings of the PERM project are used to determine a national error rate, but also reveal how Virginia measures up on a national level in the area of payment accuracy. Individual error rates are determined for Medicaid and CHIP due to separate federal funding sources. Two distinct reviews are conducted within each program: one to determine the accuracy of Medicaid eligibility determinations; and the other to determine the accuracy of payment for claims submitted by Medicaid providers.

PERM Recipient Eligibility Review

PERM eligibility activities for the federal fiscal year (FY) 2012 review cycle began in August 2011 with the submission of the DMAS sampling plan to the Centers for Medicare and Medicaid Services (CMS). This review examined active cases for the months of October 2011 through September 2012. Virginia's last review of recipient eligibility determination occurred in federal fiscal year 2009, and a large portion of the error rate was due to undetermined cases. These were cases where supporting information needed to establish eligibility could not be obtained from the local departments of social services. As a result, DMAS engaged a contractor for this PERM cycle to facilitate these reviews.

Initial PERM eligibility reviews for the 2012 cycle began in July 2012. DMAS and the contractor worked closely with the Virginia Department of Social Services to ensure that all efforts were made to obtain necessary eligibility documentation. The PERM monthly

sample consists of two main groups: active cases and negative cases. Active cases are those in which an individual is enrolled in the Medicaid or CHIP (FAMIS) program in the month of the sample. Negative cases are cases denied or terminated in the sample month. A sample of 123 active cases was examined for each month for a total of 1,476 active cases reviewed. In addition, a sample of about 83 negative cases was examined for each month for a total of 999 negative cases reviewed. The results of those reviews are displayed in the table below.

	Number of Cases	Correct Payments	Payments in Error	Total Payments
Active Case Review				
Eligible	1,442	$498,372.57		$498,372.57
Eligible with ineligible services	3	$215.30	$3,174.31	$3,389.61
Managed Care Error*	2		$4.81	$4.81
Not Eligible	29		$4,984.96	$4,984.96
Totals	1,476	$498,587.87	$8,164.08	$506,751.95
Negative Case Review				
Correct	787	N/A	N/A	N/A
Incorrect Denial	48	N/A	N/A	N/A
Incorrect Termination	164	N/A	N/A	N/A
Totals	999	N/A	N/A	N/A
*Member should have been enrolled in managed care, but were not.				

As shown in the table above, of the 1,476 active cases reviewed, 34 were determined to have eligibility errors which resulted in a total of $8,164 in erroneous payments. On August 28, 2013, CMS confirmed that Virginia's preliminary PERM Medicaid payment error rate is 0.47% and for CHIP, the preliminary PERM error rate is 5.01%. These error rates are determined by extrapolating the errors in the PERM sample through a statistical model developed by CMS.

The negative case PERM review examined 999 cases in which individuals had been denied Medicaid enrollment or terminated from Medicaid and found 212 cases with apparent errors. Since payments are not made for individuals who are not enrolled in Medicaid, there is no payment error rate for these cases. Rather, the error rate is based on the proportion of cases in the sample with errors. Final error rates will be issued in late November 2013. The details of the preliminary error rates are shown in the table below.

Program Reviewed	Active Case Payment Error Rate	Negative Case Error Rate
Medicaid	0.47%	22.94%
CHIP	5.01%	13.53%

While the overall negative case error rate for both programs appears to be high for both programs, those errors do not necessarily indicate that an eligible individual was

inaccurately denied enrollment. In fact, many of these errors result from not considering an applicant for other Medicaid programs, or from a failure to document some part of the process.

PERM Claims Review

A review of the accuracy of claims payment was also conducted over this time period. Two distinct reviews were conducted as a part of this: a data processing review that looks at whether claims were paid correctly based on information captured in the claims payment system; and, a medical record review, which examines a sample of provider medical records to determine whether documentation is accurate and complete. The data processing (DP) review identifies errors such as pricing errors, duplicate claims for a single service, and claims for a non-covered service. The medical record review identifies errors such as inaccurate diagnosis coding, insufficient documentation for billed services, and inconsistencies in the number of units billed versus documented. All sampled claims undergo DP review, but not all sampled claims require medical record review. For example, managed care capitation claims only undergo DP review.

Data Processing (DP) Review

A total of 1,347 Medicaid and CHIP claims with total amounts paid of $781,391.58 were sampled for the DP review. The results of that review are presented in the table below by program and totals for both programs. Sampled claims for CHIP are higher since this was the first year for CHIP to be audited. Subsequent sample sizes are determined by the error rate of the previous cycle.

Program Reviewed	# of Claims	# of Claims in Error	Total Amounts Paid	Overpayment
Medicaid	554	1	$ 441,045.00	$ 57.84
CHIP	793	10	$ 340,346.58	$ 5,620.55
Total	1347	11	$ 781,391.58	$5,678.39

Of those claims, 11 were determined to have data processing errors with total overpayments of $ 5,678.39. The breakdown of those errors by type is presented in the table below.

Error Type	# of Claims	Overpayment
Non-covered Service[1]	7	$ 680.04
Claim for a managed care service[2]	3	$4,989.87
Third-party liability[3]	1	$8.48
Total	11	$5,678.39

[1] Claim paid for a service that should not have been covered under Medicaid.
[2] Claim paid for a service that should have been covered by managed care.
[3] Some or all of these claims should have been covered by another insurer as Medicaid is the payor of last resort.

Medical Records (MR) Review
A total of 584 Medicaid and CHIP claims with total amounts paid of $556,681.34 were sampled for the MR review. The results of that review are presented in the table below.

Program Reviewed	# of Claims	# of Claims in Error	Total Amounts Paid	Overpayment
Medicaid	195	4	$276,510.97	$523.47
CHIP	389	3	$280,170.37	$127.73
Total	584	7	$556,681.34	$651.20

Of those claims, seven were determined to have medical review errors with total overpayments of $651.20. The breakdown of those errors by type is presented in the table below.

Error Type	# of Claims	Overpayment
Insufficient Documentation	1	$184.23
Policy Violation	3	$212.17
Administrative Error/Other	3	$254.80

Conclusion

Virginia's Medicaid eligibility error rate improved substantially from the last PERM review of recipient eligibility determination in FY 2009, down to a mere 0.47 percent in the Medicaid program. Virginia's last review of recipient eligibility determination occurred in FFY 2009 and found that local departments of social services had made errors in approximately 17 percent of cases. The vast majority (2/3) of these "errors" were undetermined cases, where information needed to establish eligibility could not be obtained. By engaging a contractor to facilitate these reviews, DMAS was able to minimize the number of "undetermined" cases and lower Virginia's final PERM error rate substantially.

Virginia's last review of claims payment accuracy occurred in FFY 2009 and estimated an error rate of 0.7 percent of fee-for-service claims. This rate was substantially lower than the national average of 1.9 percent. While results of the FFY 2012 PERM claims review have been completed and submitted to CMS, a payment error rate will not be available for the medical records review or the data processing review until CMS issues its final report to Virginia in November 2013.

DMAS staff is developing corrective action plans for issues identified in the preliminary PERM results and moving forward with any necessary process or program changes. Corrective actions can include system modifications and staff education as well as provider education through collection of overpayments and expanded DMAS audits where indicated. Once final results are issued, DMAS will submit the final report to CMS and monitor corrective actions to ensure issues are resolved.