PERM
PET
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Please meet:
Kimberly Hill, PERM Eligibility Review Supervisor
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Today’s Objectives

- Provide an overview of the history and statutory requirements of the PERM
- Provide an overview of the 2009 PERM process
- Discuss impacts on our Partners and Providers
- Discuss ways we can help you and you can help us!
Acronyms

- CDCS-Consumer Directed Community Supports
- CHIP- Children's health insurance Program
- CMS – Centers for Medicare and Medicaid Services
- DDC-Documentation/Database Contractor
- DP- Data Processing [Claims Processing]
- DRG – Diagnostic Related Group
- DRA-Deficit Reduction Act of 2005
- DT&H-Day Training and Habilitation
- FFS-Fee for Service
- FFY-Federal Fiscal Year
- FQHC-Federally Qualified Health Centers
- FFP-Federal Financial Participation
Acronyms

- HHA-Home Health Agency/Home Health Aide
- HHS-The Department of Health and Human Services
- ICF- Intermediate Care Facilities
- ICF/MR- Intermediate Care Facilities/Mentally Retarded
- IEP-Individual Education Plans
- IPIA – Improper Payments Information Act of 2002
- IPP-Individual Program Plan
- ISP-Individual Service Plans
- IHP-Individual Habilitation Plans
- LON-Level of Need
- LTC-Long Term Care
Acronyms

- MAXIS- DHS recipient eligibility system
- MDS-Minimum Data Set
- MEQC-Medicaid Eligibility Quality Control
- MIC-Medicaid Integrity Contractor
- MIP-Medicaid Integrity Program
- MMIS – Medicaid Management Information System
- MSIS - Medicaid Statistical Information System
- MR-Medical Review
- NH-Nursing Home
- NPRM-Notice of Proposed Rule Making
- OASIS- Outcome and Assessment Information Set)
- OMB-Office of Management and Budget
Acronyms

- PA-Prior Authorization or Physician’s Assistant
- PAM – Payment Accuracy Measurement
- PAR-Performance and Accountability Report
- PERM – Payment Error Rate Measurement
- PEPPER-Program for Evaluating Payment Patterns Electronic Report
- SCHIP – State Children’s Health Insurance Program
- SMERF – State Medicaid Error Rate Findings
- SSA-Social Security Act
- SSI-Supplemental Security Income
- SSDI-Social Security Disability Insurance
- WIC-Western Integrity Center (similar to RAC)
PERM is....

- PERM – Payment Error Rate Measurement
- An audit for Medicaid and Children’s Health Insurance Program (formally SCHIP)
How many federal audits are there?
PERM, Comprehensive Error Rate Testing (CERT) & Recovery Audit Contractor (RAC) Programs?

- All 3 are CMS’s Programs
- The CERT and RAC are Medicare based programs.
- PERM is a Medicaid and CHIP based Program.
- You can find more information on CERT at http://www.cms.hhs.gov/CERT/
- You can find information on the RAC Program at http://www.cms.hhs.gov/RAC
PERM & Comprehensive Medicaid Integrity Program (CMIP or MIP) OR Medicaid Integrity Contractors?

CMS’s programs BUT they are not the same.

CMIP/MIP/MIC is the result of the Deficit Reduction Act of 2005.

Focuses on Claims and medical necessity

Questions: dhs.sirs@state.mn.us

• More information can be found at:

http://www.cms.hhs.gov/MedicaidIntegrityProgram/
History and Development of PERM
PERM Overview

- CMS developed the PERM program to comply with the Improper Payments Information Act of 2002 (IPIA).
  
  http://www.whitehouse.gov/omb/financial/fia.improper.html

- PERM measures improper payments in Medicaid and the Children’s Health Insurance Program (CHIP) – susceptible to overpayments.

- PERM’s first measurement was in FY 2006 with Medicaid FFS
Prior to FY 2001

OMB/CMS developed methodology to measure accuracy in Medicaid in response to the Government Performance and Results Act (GPRA) of 1993.

No systematic means to measure improper payments in Medicaid or the Children’s Health Insurance Program (CHIP) at the national level.
PERM Background
FY 2002 –2004 PAM –Payment Accuracy Measurement

- Tested and refined methodologies to measure payment accuracy rate in fee-for-service (FFS), managed care, and eligibility for Medicaid and CHIP.
- Improper Payments Information Act (IPIA) of 2002 enacted, Medicaid and CHIP identified as susceptible programs.
PERM Background

FY 2005 –PERM Pilot
- In light of the IPIA, CMS refined methodology to measure payment error rate.

FY 2006 and beyond
- PERM program implemented starting with Fee for service

FY 2007 and Beyond
- PERM Full program implemented MA and CHIP-FFS & Managed Care-Claims/Medical Necessity and Recipient Eligibility
Authority to establish regulations

- Sections 1102 (a) of the SSA
- Medicaid Statute Section 1902(a)(6) and CHIP statute Section 2107(b)(1) of the SSA-States Provide Information
- SSA Section 1902 (a) (27) and 42CFR 457.950 –Providers to submit information for claims and payments
August 27, 2004 (Federal Register Vol. 69 No 166): PERM Proposed Rules

October 5, 2005 (Federal Register Vol. 70 No 192): PERM Interim Rule


August 28, 2006 (Federal Register Vol. 71 No 166): PERM Interim Final Rule


July 25, 2008 (Federal Register Vol. 73 No 144): PERM Modification of Data Collection

CHIPRA 2009 signed 2/4/09 effective 4/1/09 (pub Law 111-3)-modifications of process

Children’s Health Insurance Program Reauthorization (CHIPRA)

- Section 601 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires a new final rule implementing PERM requirements.

- CMS cannot publish a CHIP error rate until 6 months after the final rule is in effect.


- CMS put a hold on formal CHIP reviews but gave States the option of continuing CHIP eligibility reviews.
PERM Program Structure
PERM Program Structure

- CMS
- Contractors
  - Statistical
  - Documentation
  - Review
- State Medicaid Staff (Policy/Review)
- State Service Partners (e.g. Providers, Counties, etc.)
CMS uses a 17-state rotation for PERM. Each state is reviewed once every three years. This rotation allows states to plan for the reviews as they know in advance when they will be measured.
PERM CYCLE ONE

FFY 2006/2009:
Pennsylvania, Ohio, Illinois, Michigan,
Missouri, Minnesota, Arkansas, New Mexico,
Connecticut, Virginia, Wisconsin, Oklahoma,
North Dakota, Wyoming, Kansas, Idaho,
Delaware

• Everest Region Nepal 99
PERM CYCLE/YEAR
TWO & THREE

- **FY 2007/2010:** North Carolina, Georgia, California, Massachusetts, New Jersey, Tennessee, West Virginia, Kentucky, Maryland, Alabama, South Carolina, Colorado, Utah, Vermont, Nebraska, New Hampshire, Rhode Island

Current & Upcoming PERM Cycle Timeframes

FY 2008
- 9/07 - 9/08: Pre-Cycle
- 9/09: Final Calculated
- 11/09: Final Published
- 26 months

FY 2009
- 9/10 - 11/10: Final Published
- 11/11 - 9/11: Final Published
- CAP-mini PERM 2010-prep 2012 & start on 10/2011
- 28 months

FY 2010
- 28 months
How Does PERM Work?

Three Component Areas…
Perm Component Area

- Claim Processing

Involves:
Medicaid Fee For Service
Medicaid Managed Care
CHIP Fee For Service (on hold for 09)
CHIP Managed Care (on hold for 09)

Any services paid for by Title 19 and 21 funds-includes waiver services.
Title 21 on hold for 2009 as of 4/1/09.
Perm Component Area

- Medical Necessity

Involves:

Medicaid Fee For Service
CHIP Fee For Service (on hold for 2009)

Any services paid for by Title 19 and 21 funds-includes waiver services.
Title 21 on hold for 2009 as of 4/1/09
Perm Component Area

Recipient Eligibility

Involves all new applicants, redeterminations, on-going, denied and closed/terminated recipients for all Title 19 (MA) and 21 (CHIP) for the audit Federal fiscal year.

MN elected to continue Title 21 eligibility reviews for FFY 2009-CMS approved.
2009 Components & Sample Sizes

Medicaid

- FFS: 500 line items
- Managed Care: 250 capitation payments
- Eligibility: 504 active cases, 204 negative cases

CHIP (FFS & MC – On Hold)

- FFS: 500 line items
- Managed Care: 250 capitation payments
- Eligibility: 504 active cases, 204 negative cases
PERM CLAIMS PROCESSING & MEDICAL RECORD REVIEWS
PERM Claims and Medical Review Process

1. State Sends Universe to Statistical Contractor who conducts quality control on FFS and managed care universes submitted by states and selects random samples from universes for review.

2. Documentation/Database Contractor collects policies from states and medical records from providers.

3. Review Contractor performs medical and data processing reviews and conducts difference resolution with states.
PERM Claims and Medical Review Process

4. State receives preliminary error and re-prices-formal notification of error - 10 days to file IDR

5. HDI reviews IDR submission-reverses or upholds error. State notified and has 5 days to appeal upheld errors to CMS. CMS has the final say.

6. CMS reverses or upholds error. If upheld – pay $ to CMS and collect from provider/county.
Information Submission Requirements

Claims and MR

- MA/CHIP/Managed Care claims universe by each quarter for the FFY
- Provider contact information as requested
- Medical and other related policies, statutes, manuals, etc. in effect with quarterly updates
- Data processing systems manuals
- Any other information requested (conference calls, contractor education, resources, legislative changes, etc.)
Categories for 2009-20 Categories!

- Category 1: Inpatient Hospital Services
- Category 2: Psychiatric, Mental Health & Behavioral Health Services
- Category 3: Nursing Home, Convalescent Centers, ICF, ICF/MR & Chronic Care Hospitals
- Category 4: Outpatient Hospital Services, ER, Practitioners and Clinics
- Category 5: Dental & Oral Surgery Services
More 2009 Categories

- Category 6: Prescribed Drugs
- Category 7: Home Health Services (HHA/Supplies/equipment/appliances via HHA)
- Category 8: Personal Support Category (PCA/Respite Care/Homemaker/TCM/Private Duty Nursing/Nurse Midwife/Meal Delivery)
- Category 9: Hospice Services
- Category 10: Therapies, Hearing and Rehabilitation Services
- Category 11: Habilitation and Waiver Programs, Adult Day Care and Foster Care
More 2009 Categories

- **Category 12:** Laboratory, X-Ray and Imaging Services
- **Category 13:** Vision, Ophthalmology, Optometry and Optical Services
- **Category 14:** Durable Medical Equipment (DME) and supplies Prosthetic / Orthopedic devices, and Environmental Modifications
- **Category 15:** Transportation and Accommodations
More 2009 Categories

- Category 16: Denied Claims
- Category 17: Cross-over Claims
- Category 30: Capitated Care / Fixed Payments
  - Capitated Payments to Primary Care Case Management (PCCM)
  - Medicare Part A Premiums
  - Medicare Part B premium
  - Health Insurance Premium Payments (HIPP)
- Category 50: Managed Care
- Category 99: Unknown (Claim data individually reviewed to determine category)
PERM CLAIMS PROCESSING
FFS, Managed Care & CHIP Claims Processing Reviews

- Done by CMS contractors
- Onsite in MN
- Onsite usually one week long per Quarter
- Review sample to determine improper payments
- Looks at all aspects of claims processing
Claim Processing 2006 Lessons Learned

- Check # of units billed
- Check diagnoses
- Check billing code
- Check service dates—are the dates being entered the correct dates of service?
- Do you have a prior authorization for the service (if needed)?
- Are your dates correct?
PERM
Medical Necessity Review
PERM Medical Necessity Review

- Done offsite
- Smaller Sample than Data Processing
- Documentation collected by CMS’s Contractor from Providers DIRECTLY
- Providers submit documentation to support the service that was rendered on the service date billed
  - All documentation required as per DHS Policy, Provider Manuals & State and Federal laws

No New Requirements
Excluded from Medical Review

Fixed Payments on Behalf of Individual Beneficiaries such as Primary care case management payments, Medicare Part A and Part B premiums and Health Insurance Premium Payments (HIPP)

Fee-For-Service Denied Payments

Managed Care-Capitated payment

Cross-Over Claims
Documentation Needed for Medical Necessity Review

- Documentation to support that the service was provided on the date/s serviced & billed
- Forms, etc. required per State MA policies (e-docs)
- Documentation to support the (medical) necessity for the service
PERM Request for Records

Initial Call

Request Mailed

Request Faxed
PERM - INITIAL REQUEST FOR MEDICAL RECORDS

Provider #: 99999999999999 Sample Provider
CID #: 99999999999999
Provider Name
Provider Address
Provider Address Line 2
City, State, Zip Code

Due Date: xx/xx/xxxx
Please send ASAP but no later than the due date

Dear Medicaid and/or SCHIP Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the States, is measuring improper payments in the Medicaid and SCHIP programs under the Payment Error Rate Measurement (PERM) program. You are receiving this letter today because a claim for a service you rendered has been randomly selected for medical review under this program. We are requesting a complete copy of the medical records pertaining to this specific claim to provide supporting documentation that the service was medically necessary. Your cooperation in submitting the medical records to us as soon as possible, but no later than the due date noted above, is essential to ensure that the claim is accurately reviewed to determine proper payment. If you do not provide these records, the claim will be cited as an erroneous payment and your State Medicaid agency may pursue recovery of payments.

We are requesting medical record documentation regarding the claim identified on the enclosed Medical Record Claim Summary. A bar-coded cover sheet with a control number that corresponds to each Claim Summary is also enclosed. Please submit the specific documents listed on each bar-coded cover sheet for all identified claims.

CMS has the authority to collect this information under section 1902(a)(27) of the Social Security Act which requires providers to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for furnishing services. Section 2107(b)(1) of the Act requires an SCHIP state plan to provide assurances to the Secretary that the state will collect and provide any information required to enable the Secretary to monitor program administration and compliance and to evaluate the effectiveness of states’ SCHIP plans. The collection and review of protected health information contained in individual-level medical records for payment review purposes, as required under this act, complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Privacy Rule regulations at 45 CFR Parts 160 and 164.

In order to expedite the processing of your medical records, please make sure they are received in our office, along with the bar-coded cover sheets, no later than the due date printed at the top of this letter. Should you require additional information or have questions, please call our customer service representatives at (301) 957-2360.

Thank you for your cooperation and assistance in our efforts to ensure the integrity of the Medicaid and SCHIP programs.

Sincerely yours,

Robin Reed
Medical Record Manager
PERM Database and Documentation Contractor

Enclosures
MEDICAID PAYMENT ERROR RATE MEASUREMENT (PERM) PROGRAM

COVER SHEET
PERM Database and Documentation Contractor

<table>
<thead>
<tr>
<th>Medicaid Provider:</th>
<th>Report Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Stratum:</td>
</tr>
<tr>
<td>Identification Claim Number:</td>
<td>Service From/To:</td>
</tr>
<tr>
<td>Provider Number:</td>
<td>CID Number:</td>
</tr>
<tr>
<td>State Number #:</td>
<td></td>
</tr>
<tr>
<td>State:</td>
<td></td>
</tr>
</tbody>
</table>

Letter Sequence: 
Universe Date:

Please provide each item listed below and any additional documentation to support the above listed claim for the specified date(s) of service:

Please copy both sides of each page and please DO NOT cut off page edges when copying. Please send the original copy of this bar coded cover sheet with a copy of the medical record documents noted above. The record documents must be with the original cover sheet in order to ensure proper validation of receipt by the PERM Database and Documentation Office. Please fax documentation to: (240) 568-9122. If unable to fax documents, please send the documents to the address noted below.

PERM Database and Documentation Contractor
Attn: CID #
9090 Junction Drive, Suite 9
Annapolis Junction, Maryland 20701

Livanta LLC, PERM DDC • 9090 Junction Drive, Suite 9 • Annapolis Junction, MD 20701
PHYSICIAN CERTIFICATION FOR LTC

See: DHS MHCP Manual Chapter 27 under Utilization Review and MN Health Care Programs manual Chapter 23

A physician must certify the need for a certified NF, certified boarding care facility, or ICF/MR. **DHS-1503** form must be completed
2006 Medical Review Lessons Learned

- Failure to submit the requested and required documentation
- Case notes-record documentation fails to reflect services provided
- Follow policies and document according to policies, and regulations.
What Happens with a Data Processing or Medical Review “error?”

- State PERM Manager notified
- Time sensitive re-pricing information for claims
- File Difference Resolution to if appropriate-strict timeline
- If successful-error reversed
- If denied “error” appealed to CMS
- CMS has final say!!
- CMS REQUIRES DHS TO RETURN $$$$$ AND COLLECT FROM PROVIDER
FY 2006 National High Level Findings-FFS

Medical Review
- No Documentation
- Insufficient Documentation
- Policy Violation

Data Processing
- Pricing Error
- Logic Edit Error
- Third Party Liability Error
FY 2006 National Error Rate by Type of Error

- No Documentation: 15%
- Insufficient Documentation: 29%
- Medically Unnecessary: 11%
- Coding: 5%
- Policy Violation: 34%
- Administrative/Other: 1%
- Data Processing (non-medical error): 5%
- Medically Unnecessary: 11%
PERM
Recipient Eligibility Reviews
PERM Eligibility Component Process

IN 2009 THIS IS NOT THE SAME AS MEQC!

Eligibility component has four phases:

1. Sampling
2. Eligibility Reviews
3. Payment Reviews
4. Error Rate Calculation
CHIPRA Sec. 601(e)(2) State may elect to use data resulting from application of PERM to the application of MEQC

- Offers States the option to do this after final rule is in effect.
- Both substitution options only apply to Medicaid and Title XXI Medicaid expansion
- Does not impact stand alone CHIP
- CMS will calculate PERM and MEQC error rates separately.
- Separate reports required.
- State has to do the traditional MEQC-currently MN does a “pilot” MEQC
PERM Recipient Eligibility Review

- **Purpose**: to identify improper payments based on erroneous eligibility determinations.

- **Steps in eligibility review**
  - Submit a sampling plan
  - Construct a monthly universe
  - Randomly select a sample of cases for review
  - Conduct eligibility reviews
  - Conduct payment reviews for active cases
  - Calculate error rates
  - Report findings to CMS
PERM Eligibility Reviews

- **Purpose**: to identify improper payments based on erroneous eligibility determinations.

- **Who reviews**: Each State agency

- **Who is reviewed**: Individual recipients

- **What is reviewed**: Eligibility process
PERM Recipient Eligibility Review Sampling

- Medicaid and CHIP programs sampled separately
  - Medicaid universe: cases where services are paid with Title XIX funds
  - CHIP universe: cases where services are paid with Title XXI funds, including CHIP Medicaid-expansion cases
  - “Follow the money”
PERM Eligibility Sampling

Continued

- For PERM purposes, a case is defined as an individual beneficiary, not a household or family unit.
- Cases under investigation for beneficiary fraud - excluded.
- Anticipate sample of approx. 1416:
  - 504 active cases for each program
  - 204 negative cases for each program
PERM Sampling Universes

- Medicaid
  - Active Cases
  - Negative Cases
    - Applications
    - Redeterminations
    - All Other Cases

- SCHIP
  - Active Cases
  - Negative Cases
    - Applications
    - Redeterminations
    - All Other Cases
PERM Eligibility Sample Stratification

For each program:

- Each month the State determines the universe for the previous sample month, excludes allowed cases, and stratifies the sample.
  - Annual sample size: 504
  - Stratum 1: all applications
  - Stratum 2: all redeterminations
  - Stratum 3: all other cases.
  - Equal number of cases in each stratum.

- Negatives are not stratified; each month an equal number will be sampled (17 each month)

- State will submit monthly sample selection list to CMS.
PERM Recipient Eligibility Process

- Pull sample-Active and Negative Case
- Request and copy case file
- Request information from recipient and other sources as needed
  If recipient does not cooperate automatic error!
- Review the case with two levels of QC
- Pull claims
- Post results
PERM Recipient Eligibility Reviews

- Review active and negative cases.
- Verify eligibility as of the State’s last action.
- If that action is 12 months beyond the sample month, verify eligibility as of the sample month.
- No administrative period.
PERM Case Example #1

- For what month was the sample drawn?
  - January 2009

- When was the State’s last action?
  - August 15th, 2008; redetermination

- Was the last action within 12 months of the sample month?
  - Yes, beneficiary eligibility will be verified for the month of August.
PERM Case Example #2

- For what month was the sample drawn?
  - January 2009

- When was the State’s last action?
  - December 31st, 2007; application

- Was the last action within 12 months of the sample month?
  - No, beneficiary eligibility will be reviewed for the month of January.
Active Cases Verifying Eligibility

- Case Record will be requested
- The case record is reviewed for evidence to substantiate eligibility based on State/Federal policies. Reviews include:
  - Hardcopy documents, caseworker notes and beneficiary self declaration
  - Verification of information that is missing or outdated (more than 12 months old) and likely to change.
  - Contact with the beneficiary or other sources as necessary.
  - In-person interviews as necessary.
Required verifications for PERM MA:

1) Citizenship
2) Residency
3) Household composition
4) Bank Accounts
5) Earned and unearned income,
6) Actual enrollment in the plan for managed beneficiaries.

Reviews conducted in accordance with 42 CFR 431.974 and 42 CFR 431.980
Active Case Review
Additional Steps

- SCHIP – Verification that the beneficiary was not eligible for Medicaid
- Managed care – Verification that the beneficiary was eligible for managed care enrollment and enrolled in the correct plan
- If unable to verify eligibility (case file lacks documentation):
  - Verify independently
  - Unable to verify = error
Case Record Requested and reviewed for:
- Notice of Action to identify the reason for the denial and/or the termination
- Verification from the documentation that the reason for denial / termination was in accordance with State and Federal regulations, policies and guidelines.
- Interviews as needed
Claims and Eligibility Reviews

- Impacts all services received by the recipient for the month in review
- Claims for services provided for the month of review are collected
- If an error occurs with that eligibility review, the payment error is all of the claims paid for services for the month of review.
Recipient Eligibility Issues

- Lack of documentation to proof eligibility – citizenship/identity
- Under-reporting of income/assets
- Closed when all documentation in file
- Errors in application-date of birth
- Lack of signatures/verification
- Case file not complete-not transferred
- Undocumented NM-PC not changed to PX (Changed recently)
Recipient Eligibility Issues

- MAXIS closed but MMIS open
- MMIS closed but MAXIS open
- 17% disregard not used correctly
- Other health insurance-ESI
- Expenses not excluded-self employment-daycare-business or double counted
- Child support not calculated correctly
- Not using the correct check stubs/30 days of income
- MAXIS/MMIS Panels not completed correctly
Types of Recipient Eligibility Errors

Active Cases
- EI-eligible with ineligible services
- NE- not eligible
- U –undetermined
- L/O – liability overstated
- L/U – liability understated
- MCE1 – managed care error, ineligible for managed care
- MCE2 – eligible for managed care but improperly enrolled
Types of Recipient Eligibility Errors
Continued

Negative Cases
- IT- Improper termination
- ID - Improper denial

Other types of Notices:
- TE-Technical Errors
  Would have become errors but PERM staff were able to obtain documentation to avert an error and/or the finding did not result in the recipient becoming ineligible
- FYI- For Your Information-could potentially be an error if left unchecked!
What Happens when there is an “error” for recipient eligibility?

- PERM Manager/Supervisor calls County / MCRE Supervisor to review and discusses
- HCEA PET Team has an opportunity to review and discuss
- Letters sent out to HCEA with copy to County/MCRE for their information
- HCEA contacts county for corrective action
- HCEA reports back to PERM
- PERM reports to CMS and does CAP
When there is an Eligibility Error…

- Health Care Eligibility notified
- Fraud Referrals as needed
- Error amount is determined based on
  - Dollar amount paid for services received in the review month
- For example: Recipient in sample for January 2009—all claims for any services received in January that is processed from January to and including May and all Adjustments made within 60 days of payment is considered in error

**FINANCIAL IMPLICATIONS- PAY $$ BACK**
Error Impact......

- Claims and Medical Reviews
  - Reimburse CMS and collect from Provider
- Eligibility Errors
  - Regulation does require payment to CMS.
- Fraud Referrals as appropriate
- PERM HAS FINANCIAL IMPLICATIONS
- PAY CMS $$$ BACK
Corrective Action Plan

- Analyze “errors”
- Develop and implement a corrective action plan.

Corrective Action Plan submitted to CMS

Plan implementation crucial – 2009 NPRM has changes requiring monitoring and evaluation of the CAP
PERM in partnership with you…

- What we will do:
  - Work with HCEA and Counties to clarify policies, procedures and issues that come up
  - Work with counties, if possible, when individual case issues come up
  - Try to keep you updated via HCEA, MACSSA and other avenues

- What you can do to help:
  - Send in complete records when requested
  - Policies, Policies, Policies.
  - Keep the lines of communication flowing…
Urgh!!
TMI-TMI-TMI!

Call Us-
Let's work together and assist each other!

Use DHS Resources-Call Provider Help Desk-
Resource Specialists,
Manual, etc.

Perm - 651-431-4279

Resource Specialists, Manual, etc.
PERM Resources

- Check the DHS website:  
  http://www.dhs.state.mn.us

- Check the CMS website:  
  http://www.cms.hhs.gov/PERM

- Call Christina Baltes at 651-431-4279
PERM, PET & U Health Care Eligibility and Access Division – Program Evaluation Team (PET)

MFWCAA Fall Conference 2009
Our Objective Today

- Tell you about PET
- Provide an overview of PET’s processes relating to PERM
- Provide an overview of Corrective Action process
- Questions, feedback, suggestions…
PET

- Unit established December 2008
- Health Care Eligibility and Access Division
- Shelly Engle
- Denise Gray
- Lorrie Herling
- Jessica Pageant
PET Mission Statement

The mission of the Health Care Eligibility and Access Division’s Program Evaluation Team is to maintain the highest level of health care program integrity through continuous improvements in quality, delivery and service.
Role and Core Activities

Minnesota Department of Human Services’ Health Care Eligibility and Access assists the public in applying and accessing affordable health care, while collaborating with counties and state operations so they may better serve their population. The Program Evaluation Team seeks to improve this process through compliance reviews and corrective actions.
Our Goal is to:

- Ensure that those who are eligible receive health care through the most beneficial program.
- Make sure health care program eligibility is processed appropriately and according to state and federal laws.
- Determine where improvements may be made in policy or procedures to help workers accurately determine eligibility and ease the application and renewal processes for applicants and enrollees.
PET Activities

- Corrective Action for PERM
- Corrective Action for MEQC
- Case reviews
- Special projects with focus on integrity of MHCP
- Review and make recommendations for training and the health care programs manual
PERM and PET

- PERM discovers an error (eligibility error, technical error or an FYI)
- PET reviews and discusses error finding with PERM staff
- PERM generates error letter to PET
- PET has 60 days to respond to PERM with a Corrective Action plan
PET Process

- PET receives error letter from PERM
- PET generates a Corrective Action form to county agency or MinnesotaCare Operations (CA form goes to immediate supervisor of worker unless other arrangements have been made)
- Agency has 10 working days to provide a Corrective Action response to PET
- PET reports Corrective Action plan back to PERM
Corrective Action Activities at Agency

- Policy clarification – review Health Care Programs Manual chapters, bulletins, HINTS, training modules, etc.
- Procedure clarification – worker steps and system instructions
- Staff information sessions – target specific areas
- Discuss patterns and trends of errors at staff meetings
- Case notes
Corrective Action Update

- Training curriculum updated
- Health Care Program Manual chapters have been updated
- HINTS have been generated regarding specific topics
- Trends and patterns are being tracked for future program integrity development
Questions, Feedback, Suggestions

- What can PET do to help you with your daily workload?
  - Example: tools such as cheat sheets.
Program Evaluation Team

- Follow up questions, please contact us:
  - Denise Gray – Program Evaluation Team
denise.m.gray@state.mn.us
  - Lorrie Herling – Program Evaluation Team
lorrie.herling@state.mn.us