Payment Accuracy Measurement Project: Year 2 Final Report

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I. INTRODUCTION

The Medicaid program spends over $275 billion annually on services for eligible beneficiaries and in recent years has surpassed the Medicare program in total spending. The taxpayer dollars invested in the program must be managed and expended for needed services at reasonable rates to preserve resources. It is incumbent on everyone involved to focus on financial stewardship at all levels of the program; accordingly, there is increased attention being paid to payment integrity. The Centers for Medicare and Medicaid Services (CMS) has been urged by Congress, the General Accounting Office (GAO), the Office of Management and Budget (OMB), the Department of Health and Human Services Office of the Inspector General (OIG), and others to establish a method to measure how accurately Medicaid programs pay for services.

Payment accuracy measurement enables government to identify the extent of problems in the claims payment system, study the causes of these problems, and better focus and strengthen internal controls. At the state level, Medicaid agencies will be able to produce payment accuracy estimates for their Medicaid programs and identify existing and perhaps emerging vulnerabilities that can then be more effectively targeted with the appropriate corrective actions. At the national level, CMS will be able to estimate the size of potential improper payments and produce an overall payment accuracy estimate for the Medicaid program.

In July 2001, CMS invited states to apply to participate in a demonstration project to develop a payment accuracy measurement (PAM) methodology for Medicaid. At that time, CMS had already implemented a payment accuracy measurement program for Medicare, the Comprehensive Error Rate Testing (CERT) program. In addition, three states—Kansas, Illinois, and Texas—had conducted independent studies of the accuracy of Medicaid payments. The Year 1 demonstration was designed to provide states with the opportunity to work collaboratively to develop and test methodologies for measuring the accuracy of payments made for Medicaid services. During the first year, CMS enlisted the participation of nine states: Louisiana, Minnesota, Mississippi, New York, North Carolina, North Dakota, Texas, Washington, and Wyoming. These nine states pursued a number of different approaches that led to the development of core PAM models for Medicaid fee-for-service (FFS) and managed care programs.

In May 2002, CMS invited states to apply to participate in the second year of the demonstration project and test the core models. Twelve states applied and were awarded grants: Florida, Indiana, Louisiana, Mississippi, Nebraska, New York, North Carolina, North Dakota, Oklahoma, Texas, Washington, and Wyoming.

During the Year 2 demonstration, the Improper Payments Information Act of 2002 (Public Law 107-300) was signed into law. The Act directs each executive agency, in accordance with 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 with their annual budget requests. The definitions of improper payments cited in the Act and in OMB Circular A-11, Section 57 include payments that should not have been made or were made in an incorrect amount (both overpayments and underpayments), and payments made on behalf of ineligible recipients.

To comply with the new requirements of the Improper Payments Information Act, the definition of erroneous payments within the Act, and related guidelines from OMB, the CMS PAM model was modified during the second year of the project. These modifications included adding an estimate of payment error attributable to underpayments and incorporating a review of beneficiary eligibility.

This paper summarizes the findings from the Year 2 PAM pilot project.

- Section II describes the core PAM models for both the FFS and managed care studies;
- Section III reviews the characteristics of the participating states and their PAM projects;
- Section IV summarizes the findings and presents error rates by study type, error type, and stratum (for FFS studies);
- Section V describes other activities related to the development of the national model for payment accuracy;
- Section VI includes a discussion of issues that arose during the pilot year, and how they were resolved;
- Section VII offers next steps, including information on the Year 3 pilot and national implementation, as well as conclusions about the study.

II. PAYMENT ACCURACY MEASUREMENT MODEL

The CMS PAM model is designed to estimate payment accuracy for both the fee-for-service and managed care components of the Medicaid program. Simply defined, payment accuracy is the ratio of the dollar value of payments paid accurately to the dollar value of total payments made. The basic steps of payment accuracy measurement consist of:

1. drawing a random sample of claims or capitation payments from the universe of paid Medicaid claims and capitation payments;

2. subjecting that sample to review and audit to determine the validity of the payments made; and

3. computing an accuracy rate based on the sample.

States testing PAM in their FFS programs were instructed to draw a proportional, stratified random sample of Medicaid claims. The sampling strata are determined by major service categories defined as:[1]

- inpatient hospital services;
- long term care services;

[1] Medicaid Statistical Information System (MSIS) definitions map directly onto these service definitions. Appendix A to this report offers a crosswalk indicating which services fall under each category.

- other independent practitioners and clinics;
- prescription drugs;
- home and community-based services (HCBS); and
- other services and supplies.

The PAM model specifies that sample sizes by stratum are to be proportional to the dollar value of the line items represented by each stratum for the most recent four quarters.[2] 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 method results in over-sampling in strata for which the proportion of payments is greater than the proportion of line items, and under-sampling in those strata for which the proportion of line items is greater than the proportion of payments. When calculating the final payment accuracy rate, this over- and under-sampling by stratum is taken into account and the sample is reweighted to calculate an unbiased estimate of the overall payment accuracy rate.[3]

The review and audit consists, at a minimum, of two components for FFS claims: processing validation and medical review. Additionally, six states volunteered to perform eligibility reviews on at least 50 cases selected at random from the claims sample. Once the sample is drawn, each line item is reviewed to validate that it was processed correctly based on the information that is on the claim. The processing validation checks for the following types of potential errors:

- Duplicate item (claim);
- Non-covered service;
- Managed care organization (MCO) covered service;
- Third party liability;
- Pricing accuracy;
- Logical edit (e.g., incompatibility between gender and procedure);
- Beneficiary eligibility; and
- Data entry (clerical) accuracy.

In addition, the line item is subject to comprehensive medical review, which considers the following issues:

- Coding accuracy;
- Unbundling;
- Medical necessity; and
- Medical policy compliance.

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[2] This method 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.

[3] 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.

Error codes and definitions corresponding to each of the above errors are detailed in Appendix B.

For the managed care model, states are instructed to draw a random sample of capitation payments without stratifying by claim type. The managed care review considers the following sources of error:

- Ineligible beneficiary;
- Incorrect payment amount; and
- Fee-for-service payments made on behalf of managed care beneficiaries.

The CMS PAM model is being refined based on feedback from the pilot states regarding the usefulness and practicality of the model tested in Years 1-3 of the pilot.

III. STATE AND STUDY CHARACTERISTICS

The 12 states participating in Year 2 of the PAM project accounted for 36.1 percent of overall Medicaid expenditures in 2003, as shown in Table 1. Their proportion of Medicaid enrollment is approximately equivalent to their proportion of Medicaid expenditures.

Table 1: Medicaid Expenditures in Year 2 PAM States

State	Medicaid Expenditures
Florida	$ 10,946,214,986
Indiana	$ 4,282,435,701
Louisiana	$ 4,423,174,011
Mississippi	$ 2,853,086,305
Nebraska	$ 1,325,133,485
New York	$ 39,585,134,508
North Carolina	$ 7,050,804,888
North Dakota	$ 468,522,734
Oklahoma	$ 2,311,939,159
Texas	$ 15,420,026,696
Washington	$ 5,006,473,801
Wyoming	$ 337,284,398
Total, PAM	**$ 94,010,230,672**
Total, Medicaid	**$ 260,488,460,470**
PAM/Medicaid	**36.1%**

Source: FY 2003 CMS-64 Report.

States participating in PAM had the option of reviewing fee-for-service, managed care, or both. As Table 2 shows, seven states executed the model for FFS claims, one reviewed managed care capitation payments, and four states executed the model for both FFS and managed care. The FFS sample sizes ranged from 455 to 2354 while the managed care sample sizes ranged from 203 to 1684.

Table 2: State Participation in PAM Reviews and Sample Sizes

State	Total Sample Size	Fee-For-Service Sample Size	Managed Care Sample Size
Florida	1684	--	1684
Indiana	2301	1201	1100
Louisiana	901	901	--
Mississippi	868	868	--
Nebraska	1071	868	203
New York	1100	1100	--
North Carolina	455	455	--
North Dakota	897	897	--
Oklahoma	1579	885	694
Texas	3421	2354	1067
Washington	1149	1149	--
Wyoming	853	853	--

IV. SUMMARY OF STATE FINDINGS

A. Fee-for-service

States participating in the FFS study calculated their payment accuracy rates and a 95 percent confidence interval for these figures. Table 3 displays these calculations.

Table 3: Summary of PAM Year 2 FFS Payment Accuracy Rates

State	Sample Size	PAM Rate[4]	95% Confidence Interval
Indiana	1,201	98.8%	[96.2%, 100.0%]
Louisiana	901	99.7%	[98.6%, 100.0%]
Mississippi	868	92.0%	[91.0%, 92.9%]
Nebraska	868	96.0%	[94.8%, 97.2%]
New York	1,100	98.5%	[97.4%, 99.4%]
North Carolina	445	96.2%	[94.4%, 98.0%]
North Dakota	897	99.4%	N/A*
Oklahoma	885	96.9%	[95.5%, 98.4%]
Texas	2,354	81.4%	N/A*
Washington	1,149	97.4%	[94.0%, 100.0%]
Wyoming	853	96.2%	N/A*

* N/A indicates not available.

1. Payment error rates by stratum

Pilot states also calculated payment accuracy rates by stratum. These stratum-specific accuracy rates are weighted according to the total value of that stratum's universe of payments. Table 4 displays the results of these calculations.

Table 4: Year 2 FFS Payment Accuracy Rates by Stratum

Service Type	Average
Hospital	97.20%
Long-Term Care	99.49%
Other Practitioner	83.81%
Pharmacy	91.83%
HCBS	97.76%
Other Services	92.93%

The other individual practitioners and clinics, pharmacy, and other services strata had the lowest payment accuracy rates in the Year 2 pilot. Long term care services, home and community-based services, and hospital services had the highest accuracy rates in the Year 2 pilot.

[4] In Year 2, it was determined that overpayments and underpayments would "offset" each other in a manner that is similar to the way that both the OIG Chief Financial Officers (CFO) Audit and the CERT program have defined payment error for the Medicare program. States were asked to subtract the value of underpayments from overpayments to determine the net value of inaccurate payments.

2. Payment error rates by error code

States documented errors according to the PAM error codes listed in Appendix B of this report. These codes were used to track both the number of claims with errors and their dollar values. Table 5 displays information on the number and value of processing errors resulting in overpayments and underpayments.

Table 5: Number and Value of FFS Processing Validation Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Value of Errors	Number of Errors	Value of Errors
Duplicate item	4	$569.58	N/A	N/A
Non-covered service	9	$3,586.83	0	$0.00
MCO-covered service	1	$23.75	0	$0.00
Third party liability	10	$12,184.86	1	$1.00
Pricing error	56	$67,246.57	39	$7,475.06
Logical edit	17	$1,884.70	0	$0.00
Ineligible recipient	6	$7,248.17	N/A	N/A
Data entry errors	13	$55.93	1	$449.33
Other	18	$2,591.82	1	$969.69
Total	**134**	**$95,392.21**	**42**	**$8,895.08**

* N/A (not applicable) represents an error category that cannot result in an underpayment.

The distribution of processing errors varied by state but the greatest number appeared to emerge from pricing errors, logical edits, and data entry errors. Pricing errors accounted for the majority of errors in terms of their dollar value. Errors resulting from third party liability and ineligible recipients also had high dollar values, likely because those types of errors nullify the entire value of the claim. In the findings reported by the Year 2 pilot states, underpayments occur less frequently than overpayments. The majority of underpayments emerge from pricing errors. Note that while the same error categories are used, some of these cannot result in any underpayment (e.g., ineligible beneficiary).

Table 6 displays the number and value of medical review errors that resulted in overpayments and underpayments. The biggest sources of inaccurate payments resulting from medical review errors identified by the Year 2 pilot states are documentation errors, coding errors, and medically unnecessary services. "Other" errors make up a substantial number of errors but accounted for proportionally less dollar value of error.

Table 6: Number and Value of FFS Medical Review Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Value of Errors	Number of Errors	Value of Errors
No documentation	143	$58,124.44	N/A	$0.00
Insufficient documentation	445	$230,220.81	N/A	$0.00
Coding error	99	$167,767.47	9	$4,610.61
Unbundling	2	$35.46	N/A	$0.00
Medically unnecessary	91	$124,336.19	N/A	$0.00
Administrative error	8	$3,466.53	0	$0.00
Policy violation	60	$10,415.27	0	$0.00
Other	374	$36,214.87	16	$23,506.29
Total	**1222**	**$630,581.04**	**25**	**$28,116.90**

* N/A (not applicable) represents an error category that cannot result in an underpayment.

B. Managed Care

Five states provided results from Year 2 reviewed managed care capitation payments: Indiana, Florida, Nebraska, Oklahoma, and Texas. The results from these studies are presented in Table 7 below. On the basis of the results from these states, it appears that payment accuracy in managed care is higher than in FFS programs. This is to be expected, given that routine capitation payments can be more fully automated by computer systems. Additionally, managed care payments require only a processing review and not an additional medical review in the PAM study.

Table 7: Summary of PAM Year 2 Managed Care Payment Accuracy Rates

State	Sample Size	PAM Rate	95% Confidence Interval
Florida	4,107	99.2%	[95.48%, 100.00%]
Indiana	1,100	100.0%	[100.0%, 100.0%]
Nebraska	203	100.0%	[100.0%, 100.0%]
Oklahoma	694	99.4%	[98.8%, 100.0%]
Texas	1,067	97.5%	N/A*

* N/A indicates not available.

Table 8 presents the number and value of managed care errors resulting in overpayments and underpayments. Managed care errors resulting from ineligible beneficiaries were the most frequent and most costly type of error. While states were asked to track errors resulting from FFS claims that should have been covered by a managed care enrollee's MCO, these errors were not factored into the accuracy rate calculations. As in the FFS reviews, in managed care underpayments occurred much less frequently than overpayments.

Table 8: Number and Value of Managed Care Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Value of Errors	Number of Errors	Value of Errors
Ineligible beneficiary	90	$10,751.28	N/A	N/A
Incorrect payment amount	64	$10,143.66	36	$12,230.00
FFS payment in error	70	$4,631.38	0	$0.00
Other	30	$0.00	0	$0.00
Total	**254**	**$25,526.32**	**36**	**$12,230.00**

* N/A represents an error category that cannot result in an underpayment.

C. Eligibility

In February 2003, the PAM model was modified to comply with the Improper Payments Information Act and a limited review of the eligibility of beneficiaries in the sample was added. Six of the twelve Year 2 states volunteered to conduct eligibility reviews. States were given the choice of performing Option 1, a full Medicaid Eligibility Quality Control (MEQC) review of beneficiary eligibility at the time of service, or Option 2, a re-review of the accuracy of the most recent eligibility determination or re-determination, for a small subsample of cases. The subsample excludes cases where Medicaid eligibility is an automatic byproduct of eligibility for other programs (e.g. TANF, IV-E, Refugee Assistance, etc.). Four states chose to follow Option 1 while one pursued Option 2. The sixth opted to subject the 50 sampled claims to both Option 1 and 2 reviews in order to compare their cost and efficacy.

Table 9: State Approaches to Eligibility Reviews in PAM

State	Review Option	Sample Size (cases)
Florida	1	353
Mississippi	1	104
North Carolina	1 & 2	100
Oklahoma	1	86
Texas	2	100
Wyoming	1	50

The six states participating in the eligibility review were asked to discuss the findings in their final report as well as any issues or obstacles they encountered in the process. Their comments have been briefly summarized:

- Florida verified the eligibility of 353 managed care enrollees. The error rate for the 307 for which eligibility could be checked was 3.3 percent. Eligibility could not be validated for another 14.3 percent. The state also pointed out that its overall payment accuracy rate would be substantially lower if eligibility error was projected to the entire

population, rather than included only for that portion of the sample in which error were determined to have occurred.

- Mississippi reviewed 104 cases. The state found two cases to be ineligible at the time of service representing an overpayment of $4,681. Both cases emerged from its inpatient hospital stratum and reduced that stratum's accuracy rate in the final calculations.
- North Carolina subjected 50 claims to eligibility reviews under both Options 1 and 2. Of the fifty recipients reviewed, one eligibility error was found and it was detected under both protocols. Moving from Option 2 to Option 1 yielded no improvement in accuracy and required 53% more time/cost. However, the state's eligibility director strongly preferred Option 1 since it allows the state to pursue corrective actions as a result of the determination.
- Oklahoma reviewed 86 cases for eligibility. The state found two ineligible recipients in its managed care subsample and three ineligible recipients in its FFS subsample resulting in a total of $2,770 in payment errors.
- Texas reviewed 50 FFS cases and 50 managed care cases. The majority of errors were for missing Social Security Numbers after more than a year's enrollment. Out of the 12 errors identified, 8 were for missing Social Security Numbers.
- Wyoming reviewed 50 cases. Two cases were identified as being ineligible in the month of application. One of the two ineligible cases was subsequently found eligible in the service month. The other case was identified as having an understated liability for both the month of application and the service month.

V. OTHER ACTIVITIES RELATING TO THE DEVELOPMENT OF THE NATIONAL MODEL

During the Year 2 pilot, several additional studies were conducted in order to learn more about the process for executing payment accuracy measurement studies and how the studies themselves differed across states. These projects contributed to the overall knowledge base that informs the design of Year 3 of the pilot project as well as national implementation.

1. **Cost and efficiency study**. States participating in Year 2 of the PAM pilot were surveyed and asked to supply data on the amount of time and money they expended for each of the major project activities. They were also asked to offer any suggestions for other states as to what practices had and had not worked well. The cost and efficiency study summarizes this data and seeks to provide cost information for CMS and state officials as PAM enters its final year as a pilot project and is implemented nationally. A number of operational suggestions were also identified during the study, which were included in a "Practices for Consideration" list already circulated by The Lewin Group.

2. **Medical record re-review**. In order to identify differences across states in the way that medical records were reviewed in conjunction with PAM, Year 2 states were asked to supply documentation for 25 records that had been reviewed along with the policies and regulations relevant to each claim. Of these 25 records, 15 were to have been designated as errors. The remaining 10 were a random sample of the PAM claims. Nurse reviewers

at The Delmarva Foundation re-reviewed these claims to identify differences in the method for conducting medical reviews.

In support of the pilot study of payment accuracy, several sampling and analysis tools have been developed for use by the states. These will be tested and modified over the course of the Year 3 pilot. They include:

1. **Sample size calculator**. The sample size calculator is a spreadsheet-based tool that allows the user to estimate sample sizes necessary to achieve a desired level of precision. States enter the total payments for each stratum for a representative time period and enter the total number of paid line-items in the state for the calendar year. The program suggests a standard deviation and coefficient of variation, but states can also enter their own preferred values or supply better assumptions regarding the variance in the underlying payment data. Once this information is included, the program calculates the approximate number of line items to review in order to meet the CMS PAM precision requirements.

2. **MedQuest.** This is 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. Screens were created for each type of review and for entering medical review, payment information, and error codes for each claim reviewed. Use of MedQuest is optional for states, but it may help project directors ensure that all aspects of the model and reporting requirements are being met.

3. **Error rate calculator.** An error rate calculator is under development that will assist states in calculating final error rates using results from the study. States can use the tool to determine their error rate or to verify the calculations made by their statistician. While not required, the calculator will promote standardization and uniformity across states. It will be available for use during the Year 3 pilot and for future PERM implementation.

During the Year 2 pilot, none of these tools were required to be used by the states. In the Year 2 pilot, most of the participating states used a version of the sample size calculator and some used MedQuest. The error rate calculator was not yet available.

VI. ISSUES AND RESOLUTIONS

A. Sampling

Many states encountered difficulties pulling their samples from the universe of Medicaid claims. Their specific issues were related to a number of steps in this process, including the removal of Medicare crossover claims, challenges in assigning claims to the appropriate stratum, and difficulties coordinating with the MMIS contractor.

Florida's issues with sampling were primarily administrative in nature. It experienced serious delays in the project timeline due to difficulties obtaining data from the MMIS vendor.

> *In general, the project went smoothly after the contract was signed with the vendor. The project would have been completed on time without the delay in contracting. The most difficult task was preparing and validating the computer system to determine the validity of payments.*[5]

While Florida opted to draw large enough samples to generate statistically significant error rates for each managed care plan, the end results indicated that this approach might not have been necessary:

> *Florida originally designed the study so samples were large enough to apply to the entire HMO [Health Maintenance Organization] payment to a particular HMO with the belief that error rates would vary significantly by HMO. Some variation was found, but the overall error rate was so low that a large sample may not be justified. It should be noted that most of the study cost is in programming, not original data collection, thus the added cost of increasing sampling is small in contrast to fee-for-service analysis when payments are not based on health status. It also suggests that once a vendor is selected, changing vendors could be costly as all the programming would need to be redone.*[6]

Like Florida, Mississippi experienced delays in receiving the PAM sample from the state's fiscal agent. Ultimately, this caused a significant shift in the project timeline since the validated sample was not received until August 2003.

> *The most significant issue in the PAM Year 2 study was obtaining the universe from the fiscal agent. A nearly four-month delay in receiving the data had obvious repercussions on the timeline. A request was issued to the fiscal agent in November 2002 with expectation of receiving the needed information by January 2003. The information was not received until April 2003. Associated with the delay in receiving that universe was the problem of obtaining a valid sample because the universe included adjusted claims that CMS (after Mississippi's finally receiving the universe report) decided to exclude. DOM [Division of Medicaid] elected to proceed with the existing universe report and exclude adjustments from the sample. The removal of adjustments proved to be more time-consuming than anticipated. As a result, DOM did not have a complete, valid sample until August 28, 2003. This also affected the Quality Control Process that was often deferred due to the urgency of reviewing the initial ICNs. These issues related to the delay in receiving the universe report were resolved by intense teamwork and request to CMS for a no-cost extension.*[7]

Mississippi proposed developing a more collaborative relationship with its fiscal agent. Other states planning to participate in PAM may benefit by approaching their vendors pro-actively, rather than waiting until it is necessary to draw the sample.

> *The major problem encountered by Program Integrity during the course of the PAM Year 2 study was the difficulty in obtaining the necessary information to conduct the*

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5 Florida Agency for Health Care Administration. "Medicaid Payment Accuracy Measurement: Year 2 Pilot Project," December 30, 2003: 3.

6 Florida, 2003: 4.

7 Mississippi Division of Medicaid. "Mississippi's Payment Accuracy Measurement Process: Final Report," December 10, 2003: 9.

study within the time frame of the grantor, CMS. The DOM should require a more responsive relationship with the fiscal agent on such special projects as this PAM study.[8]

Nebraska noted that it would have wanted to look specifically at payment accuracy in mental health and substance abuse services, in part because they constitute a significant proportion of expenditures. Currently, these services are sampled within the long-term care stratum.

Mental Health/Substance Abuse is a high expenditure (claims and management) for Nebraska yet, it seems to have been lost in the long-term care stratum. A recommendation for future projects would be to identify this service as a unique stratum to allow more specific findings.[9]

New York also experienced delays in drawing its sample. However, its difficulties were primarily the result of including/excluding certain claim types and stratifying the claims rather than administrative hurdles encountered when dealing with the vendor.

The sampling process was complicated, involving stratification, manipulation of large volumes of claims and identification of services to be included/excluded from the universe/sample. Delays were encountered in obtaining the universe and sample from system staff, which had competing demands on their time and resources. A contract statistician was used to determine the stratification and sampling plan. Frequent communication, interaction and follow-up with the statistician and system staff regarding the universe/sample specifications and production was employed, including discussion of questions and providing information, as needed.[10]

North Carolina inquired as to the possibility of sampling on a different time frame. A number of states have asked informally about this possibility and expressed interest in drawing the sample year-round rather than just during the first quarter.

Given the delays encountered by numerous PAM states, would it be possible for OMB-CMS to base the sample universe on a different time frame? Drawing the claims from the first quarter of the federal fiscal year exhausts four months or more of time needed to complete the PAM review cycle.[11]

North Dakota pointed out that drawing a dollar-weighted sample of claims tends to produce a sample that is relatively heavy in long-term care claims. These claims are more complicated to review than most other claims and require more resources.

Of the 897 claims in our sample, 279 were LTC claims. This represents 31% of the claims reviewed. The documentation needed for long term care claims is more detailed than the other claim categories and it takes a considerable amount of time to review each

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8 Mississippi, 2003: 1.

9 Nebraska Health and Human Services Finance and Support, Medicaid Division. "Nebraska Medicaid Payment Accuracy Measurement (PAM) Project Final Report," April 19, 2004: 5.

10 State of New York, Department of Health. "Medicaid Payment Accuracy Measurement Demonstration Project: Year 2 Final Report," December 29, 2003: 14.

11 North Carolina Division of Medical Assistance, Program Integrity. "CMS Payment Accuracy Measurement (PAM) Pilot Project: North Carolina Final Report – PAM Year 2," February 24, 2004: 11.

claim and documentation. Prior to drawing the sample, we had assigned one nurse to complete the LTC claim reviews; however, we enlisted the assistance of four additional nurses to assist with the reviews. North Dakota requested an extension to its PAM Grant project so we had adequate time to complete the reviews of LTC reviews. We are concerned about staffing the PAM Grant in the future because of the large sample of LTC claims. Alternative methods for weighting the sample need to be considered to avoid a sample size that is neither realistic, nor provides any additional information on payment accuracy.[12]

North Dakota also experienced some technical difficulties working with its data warehouse. Some of these issues emerged as a result of communication lapses.

We rely on our decision support contractor to pull the universe, and subsequently, the PAM sample. This did not occur in a timely manner and delayed the ability to send the initial letter for the request of documentation. We are hopeful, now that our strata are established and the process designed, that this process will be more expeditious in the future.

A misunderstanding led to non-Medicaid claims being included in the sample. The data warehouse was instructed to exclude all non-Medicaid claims from the universe, however, we determined shortly after the initial letters were sent to providers that a group of [claims for state-funded services for persons with severe and persistent mental illness] were included in the sample (for the HCBS stratum). We replaced the claims in the sample and proceeded with collecting the information; however, it added additional time to the process of collecting documentation.[13]

Oklahoma experienced delays drawing a sample due to the implementation of a new MMIS system. A number of other states have expressed that this may be an issue in the future, as states periodically reprocure MMIS vendors, update systems, and implement other system changes (e.g., HIPAA).

The most significant issue encountered was the implementation of our new MMIS system. The initial testing of this data and the subsequent validation of the data we extracted was resource intensive.[14]

Texas also experienced difficulties sampling claims but only realized the nature of the problem after it had begun receiving responses to record requests. States should be encouraged to validate their samples in several different ways to prevent this from occurring.

The final PAM sample was not compiled and validated until June 2003. When the sample was certified as valid, the initial request letters for the medical records were sent out immediately. The first records for the outpatient stratum started arriving in July and during their utilization reviews a pattern started emerging with the billed and paid amounts of the sample services. Online research showed the sample services that were

[12] North Dakota Department of Human Service, Medical Services Division. "Medicaid Payment Accuracy Measurement Demonstration Project: Year 2 Final Report," March 25, 2004: 5.

[13] North Dakota, 2004: 6.

[14] Oklahoma Health Care Authority. "Year 2 Medicaid Payment Accuracy Project Final Report," December 23, 2003: 2.

part of a claim with multiple services had the total claim billed and paid amounts instead of the actual service detail billed and paid amounts. Over the next two months, the other paid amount discrepancies with the long term care, home health community based and transportation services emerged. Because it was too late to reselect another sample, the project team did the following to correct the sample paid dollar amounts.

For the Year 3 PAM project, the project team is requesting sample universes for each stratum from the OIG Medicaid Fraud and Abuse Detection System (MFADS) and will select the sample following a thorough screening to confirm data quality.[15]

Wyoming identified a number of systemic issues it encountered when sampling claims. While these concerns appear to have been resolved in Year 3, they note that the sampling specifications established by PAM must be sufficiently flexible to accommodate all of them.

There were several issues identified in the sampling universe. One main issue is that juggling the stratum numbers because of the MSIS/Federal Category of Service (COS) codes required for the study and the way this data was setup/available in QueryPath made it necessary to run two queries for each stratum by Facility Path and Medical Path then add the result sets together. Also, two of the strata were such large data result sets that we had to have ACS [the Wyoming MMIS contractor] run them and put them in Access and apply the randomly selected line numbers (for the sample claims) to the combined data result set. These issues have been resolved for Year 3. Wyoming now has OmniMAR running and we will be able to use Business Objects to access all of the PAM required MSIS/MARS Federal COS codes out of one universe. There will continue to be a problem with the file size restriction on electronic transfer/receipt of very large files, however the data set can be saved to CD if needed. Other items that needed to be included in the initial random stratum database are the Rx number for prescription drug claims and the TCN (transaction control number) on all claims. These will be included in the Year 3 sampling universe.[16]

B. Medical record requests

In Year 1 of the PAM project, most states commented on the difficulties they experienced retrieving medical records from providers. Despite efficiencies learned from the Year 1 pilot, making medical records requests and following up on those requests continue to take up a significant amount of time and pose challenges for each of the states.

The Health Insurance Portability and Accountability Act (HIPAA) took effect in April 2003. As a result, many states reported that providers had raised concerns about the release of medical records. New York noted the following:

Problems were encountered obtaining the medical records/documentation from providers for the sample claims. These problems included contending with no response and issues

[15] Texas Comptroller of Public Accounts and Texas Health and Human Services Commission. "Payment Accuracy Measurement Year Two Demonstration Project: Final Status Report," January 30, 2004: 11.

[16] Wyoming of Health, Office of Medicaid. "Medicaid Payment Accuracy Measurement Year 2 Pilot Project: Final Department Report," October 31, 2003: 6.

> *raised by the providers, such as the right to records and the HIPAA. In advance of addressing the documentation request letters, PAM staff called the providers to obtain a contact person for each. Use of a contact person increased the response to the initial request letter. Follow-up was done via fax and telephone as needed, which was successful in procuring outstanding documentation.*[17]

North Carolina discovered that obtaining accurate contact information for providers is one of the most cumbersome tasks in the process of requesting records.

> *Delays in obtaining a recipient's medical records for review continue to account for a substantial amount of time in the claim reviews. Providers often fail to notify the agency when they change their addresses, phone numbers, etc. This often requires multiple contacts (mail, phone, and fax) to identify the location of claim records, which occasionally are split between two provider locations.*[18]

North Carolina also found that informing them of possible recoupment of a claim as a method of last resort did motivate noncompliant providers. Other states reported using other punitive mechanisms such as proposing regular audits of that provider's claims.

> *Our experience with missing medical records or with non-responding providers suggests that recoupment letters do "motivate" providers to "find" the appropriate documentation. Recoupment requests should be used with non-responders in PAM reviews before coding a claim as an error due to non-response.*[19]

North Carolina reported difficulties finding space to store PAM records to comply with the need to retain documentation for three years.

> *Retention time for medical records obtained for claim reviews that are not in error can and do generate storage problems. North Carolina practice is to request records from providers that span dates of service under review so the amount of records to store for 3 years is high. The medical review organization estimates an average of 50-1,000 pages depending on the LOS [length of stay] for each inpatient hospital claim under review.*[20]

North Dakota cited a need to further tailor its record request letters so that they were more stratum-specific. Most states found this to be the case and plan to continue improving upon previous versions of these letters.

> *In Year 1, we identified that the letter of request needed to be more specific for the various provider groups. We tailored the letter in Year 2 and created a separate letter for long term care claims. This assisted with the return of correct documentation; however, we have identified additional changes needed to the letter for future years of the grant to*

[17] State of New York, 2003: 15.
[18] North Carolina, 2004: 10.
[19] North Carolina, 2004: 11.
[20] North Carolina, 2004: 12.

reduce the number of telephone inquiries and minimize the submission of incorrect or incomplete information.[21]

Like many other states, North Dakota found that there were a number of providers that failed to respond to repeated requests for documentation. In these cases, threatening recoupment or future audits may improve response rates.

We had nearly 100 providers that did not respond to the initial request for information. We have issued a second request and information continues to be submitted. Based on the results from Year 1, it was decided that we would recoup the dollars from providers, which failed to reply to our request for information.[22]

North Dakota opted not to use the MedQuest tool that was distributed to states; instead it chose to develop its own electronic tracking system. This database was demonstrated at the September 2003 PAM conference in Baltimore, MD and made available to states interested in utilizing it.

The North Dakota staff was very interested in using the software prepared by Medquest; however, its functionality was not helpful in providing efficiency to the process. A staff member from our Finance office created an Access Database to manage PAM grant activities. The design allows the claim line-item information to be transferred from our data warehouse directly into the database. Once the claim information is in the database, we are able to prepare letters, by stratum or by those that have not responded to a previous request for information. In addition, the staff conducting the medical and processing reviews are able to enter information on errors. The system continuously tracks claims with errors, the percentage of claims reviewed and the payment accuracy rate. We intend to evaluate the database in early 2004 to ensure it will meet our needs in future years. It will be modified, as necessary, to ensure future activities are conducted efficiently.[23]

Like North Dakota, Nebraska also opted not to use the MedQuest software. Still, the process of tracking records necessitated that the state develop its own internal system.

Staff participated in MedQuest software development meetings, but it was decided that this tool would not be useful for this year's project. The technical support for the tool appeared to be minimal and the tool itself was still under development. Nebraska developed its own tools for tracking records and generating review results.[24]

Oklahoma generally found the process of requesting records to be one of the more cumbersome elements of the PAM project.

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[21] North Dakota, 2004: 5.
[22] North Dakota, 2004: 6.
[23] North Dakota, 2004: 5.
[24] Nebraska, 2004: 5.

> *Obtaining medical record documentation was burdensome. Despite following PAM guidelines and other state examples, our first attempt often failed to give all the needed information to conduct the medical review.*[25]

Washington's comments regarding record requests touch on similar sentiments conveyed by Oklahoma. In some sense, it is expected that a certain proportion of providers will fail to respond to initial inquiries. States participating in future years of the PAM project should be forewarned about this trend.

> *A total of 612 different providers were identified. In a classic example of the 80/20 principle, about 80% of the providers responded in a timely fashion with appropriate documentation, utilizing about 20% of the data collection resources. The remaining 20% of providers required considerable follow-up effort: phone calls, explanations, faxes, e-mails, and/or copies of original requests, using approximately 80% of the data collection resources, to obtain the information needed.*[26]

Washington also points out one way to decrease the effort expended in making record requests. In many cases, requestors should verify names and contact information before sending out these requests. A number of states concurred with this strategy in their interviews for the cost and efficiency study.

> *Follow up phone calls began to non-responding providers approximately four weeks after the requests for documentation were mailed. At that time, the PAM project was understaffed, so additional follow-up calls were delayed. Most of the follow-up calls revealed that initial requests never got to the proper addressee, personnel changes produced a different contact person, or provider phone number or address had changed. Re-requests were then faxed to the correct contact, and contact information was updated for use in PAM Year 3.*[27]

Also, Washington noted that for pharmacy claims, it may be more efficient to contact corporate offices, rather than individual pharmacies.

> *Washington discovered many of the pharmacy requests sent to major chain stores, such as Walgreen's or Ride-Aid, were actually forwarded to their corporate headquarters, where a single individual was responsible for the entire set of Washington requests. We discovered it is possible, indeed preferable, to make the requests directly to the corporate headquarters, thus eliminating intermediary steps. We anticipate sending batched requests to corporate headquarters as frequently as possible in PAM Year 3.*[28]

Much like North Dakota, Wyoming cited a need to further tailor record request letters so that they would be specific to each stratum. Most states conveyed that this was particularly true of pharmacy claims.

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[25] Oklahoma, 2003: 2.

[26] State of Washington, Department of Social and Health Services. "Final Report: Year 2 Payment Accuracy Measurement Project," December 16, 2003: 5.

[27] Washington, 2003: 6.

[28] Washington, 2003: 6.

> *The initial provider request letter needed to be more specific and detailed to each stratum. We also found that many providers requested social security numbers and/or the date of birth for the recipient that we were requesting records. Specific to the prescription drug stratum, a different letter needs to be created for the nursing home providers as the documentation for these claims is different from other pharmacy claims. Also, the prescription number of the claims selected must be included in the provider letter for all claims on the prescription drug stratum. The letters have been revised for Year 3 to include the additional information.*[29]

Wyoming felt there was a need to establish an official timeline and protocol for the receipt of records. Currently, the PAM project has not established an official policy on this issue. As a result, some states do not consider records received after a certain date and others will accept records up until the point at which their final report is submitted. It may be prudent to consider the adoption of a formal policy at some point in the future.

> *We have determined that we need a formal protocol and time frame for retrieving incomplete documentation. One possible solution is if records are not submitted to our office by the date stated in the initial letter, a follow-up letter be sent by certified mail. If there is still no response within a certain number of days, the reviewer will call the provider. If, after the three attempts with a time frame protocol to obtain the records, there is still no response, the file will be referred for payment recovery.*[30]

Wyoming also described some difficulties it had run into tracking records with a paper system that failed to capture enough information. In the future, they will have the option of refining their own system or utilizing the MedQuest.

> *We found that our internal tracking spreadsheet and reviewer forms were lacking the TCN and other information which could maximize the reviewer's time and enhance cost efficiency. The tracking forms should also include fields with number of days for follow-up letters of request, phone calls, faxes, etc. We will refine those forms for Year 3.*[31]

C. Administration and staffing

In Year 2 of the PAM project, pilot states increasingly cited administrative and staffing issues as causes for delays in their projects. A number of these have already been discussed above. Many states had problems recruiting and retaining appropriate staff to conduct medical reviews, because Medicaid-specific expertise and training is needed.

Nebraska encountered a number of resource limitations during its Year 2 project. This was particularly true of staff time. As a result, it was forced to request an extension to its Year 2 report and decided not to participate in Year 3 of the project.

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[29] Wyoming, 2003: 7.
[30] Wyoming, 2003: 7.
[31] Wyoming, 2003: 7.

> *In Nebraska, a major issue during the project has been staff resources associated with the project. A substantial amount of time was needed to conduct this. Given the number of errors identified and in particular the dollar value associated with the errors, there are other more focused methods to accomplish a reduction in payment errors.*[32]

Nebraska also experienced difficulties training nurse reviewers, relating largely to its shortage of manpower. Competing priorities prevented more experienced program staff from providing technical assistance that was as detailed as the project team would have wanted.

> *There were some difficulties encountered due to the limited availability of program staff in Nebraska to answer questions regarding practice vs. policy in specific program areas. All staff were working on HIPAA activities, responding to legislative needs, and end of the fiscal year functions. The training of the registered nurses doing the medical review became an issue. Program staff have not always understood what information the Nurse Reviewers needed and it was not possible to cover every potential question in a relatively brief training. In the future, Nebraska would need to provide additional training or operationalize a specific process for technical assistance.*[33]

New York notes that it had insufficient staff resources at the state level. A number of other states encountered similar problems and these were often exacerbated by the fact that many state legislatures imposed hiring freezes in 2002-2003 in response to budget deficits. In many cases, states contracted out some or all of the medical review work.

> *Insufficient staff resources were available at the State level to perform the PAM study using in-house staff. Funding from the CMS PAM grant was used to hire contract staff.*[34]

New York found these staffing shortages to be particularly acute amongst medical review nurses. In order to compensate, the state offered contract nurses intensive training.

> *Difficulty was encountered finding and hiring contract nurses for the State PAM team who had sufficient knowledge and experience in Medicaid, managed care, fee-for-service, systems and payment accuracy review to perform the PAM study. To overcome the steep learning curve involved, intensive training, including on-the-job, was used with the contract nurses who were hired. This successfully resulted in the nurses possessing the skill level necessary to perform the study.*[35]

Even when it was able to hire contract nurses to perform medical review, New York discovered that it was difficult to retain them. A number of other states also noted retention problems in their cost and efficiency study interviews.

> *Difficulty retaining contract staff for the duration of the project, as the positions were grant funded with an end date. For this reason, the contract staff actively sought permanent employment elsewhere during the project. As a result, two nurses and the*

[32] Nebraska, 2004: 5.
[33] Nebraska 2004: 5.
[34] New York, 2003: 14.
[35] New York, 2003: 14.

administrative assistant left prior to completion of the project. Because of the training needed and the steep learning curve involved, new contract nurses were not brought in to replace those who left. Instead, the remaining nurses assumed the workload. To finish the project at the end, State nurses were used to supplement the contract nurses. This approach successfully resulted in project completion. The contract administrative assistant who left was not replaced and State staff assumed those duties.[36]

North Carolina experienced a similar retention issue, but placed a high priority on obtaining experienced Medicaid staff for the Year 2 pilot.

Resignations of experienced medical staff during the medical records review phase costs the project considerable time. Several staff resigned during the records review phase of PAM Year 2. In Year 1, we had hired retired nurses who had previously worked for Program Integrity and who had experience in auditing claims. Year 2 required more training to get the staff acquainted with the PAM project as well as MMIS and other reference/investigative tools. The PAM staff is employed part time (twenty hours per week). One nurse reviewer was hired to fill another nursing vacancy in Program Integrity and then was loaned back to complete their assigned reviews this year. The PAM unit lost medical review staff to internal promotions on two occasions. The PAM unit was also slowed by replacement staff with no prior Medicaid experience who needed more "on the job training" by existing staff. No amount of training can replace 20-30 years of Medicaid experience.[37]

Citing an inability to renew a contract for nursing home reviews, North Carolina lost online access to this data. Setbacks such as this are virtually impossible to anticipate, yet can delay a PAM project by a number of months.

Medical Review of North Carolina's (MRNC) contract with DMA [Department of Medical Assistance] for nursing home reviews was not renewed, which resulted in loss of online access by MRNC staff to DMA data warehouse, provider, and recipient eligibility files. PAM staff compensated and printed all prior approval screens for MRNC staff. Online access for MRNC is being restored for next fiscal year.[38]

North Dakota opted not to contract out Year 2 of the PAM project as it had in Year 1. However, as a result of staff reductions made by the legislature in response to budgetary shortfalls, this proved to be much more difficult than it had originally anticipated.

In Year 1 of the PAM Grant, an outside contractor was hired to coordinate the efforts in North Dakota and conduct the medical and processing reviews. In Year 2, Medical Services staff performed all aspects of the grant activities. While the expertise level of Medical Service staff is high, the time available to commit to this project was limited. In addition, budget cuts made during the 2003 legislative session led to a reduction in force of several staff members throughout the Department, including the staff member from

[36] New York, 2003: 14.
[37] North Carolina, 2004: 10.
[38] North Carolina, 2004: 11.

> *Research and Statistics, assigned to the PAM Project. With daily work and reductions in staff, we struggled to accomplish the requirements of the project.*[39]

Texas was one of the three states selected for a site visit in conjunction with the cost and efficiency study. At that time, the agency conducting PAM was undergoing a massive reorganization. These circumstances contributed to a delay in completing the PAM project.

> *Finding the appropriate business expert for the benefit programs new to the project team turned out to be more of a problem than anticipated. The Texas Medicaid agencies are undergoing a major reorganization mandated by 2003 Texas Legislature. The reorganization is a consolidation of 12 state agencies into the Health and Human Service Commission with four departments. Hopefully, the personnel that the project team will need to rely on for program expertise will remain to assist with the Year 3 PAM project.*[40]

D. Medical review and quality control

In their Year 2 final reports, states expressed a number of concerns relating to medical reviews. As expressed in cost and efficiency study interviews, they often encountered difficulties maintaining consistency across reviewers. Similarly, the PAM project itself found it difficult to maintain consistency in medical review across states. The re-review of claims was intended to address this issue, though this is an issue that will most likely persist throughout the project.

Mississippi notes that to the extent that states are able to discover "problem areas" and apply corrective actions in those strata, PAM can be an extremely valuable tool.

> *Results of the study showed that overpayment errors due to lack of medical necessity in Long Term Care accounted for nearly two-thirds of the total overpayment cost in the sample. The DOM should develop more well-defined and measurable criteria for both nursing home admission and continuation of care.*[41]

Mississippi also planned to follow up on those claims found to have errors. Many states reported doing so in Years 1 and 2, and discovered patterns of fraud and abuse amongst certain providers.

> *Program Integrity should review all of the ICNs with errors to determine if additional provider audits are required to identify possible fraud/abuse and recoup overpayments.*[42]

Mississippi's comment on rate changes touches on the issue of states having to keep track of ongoing policy changes and when these changes occurred. Since the sampling period for PAM extends through three months, states must be cognizant of any shifts that occur during that time.

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[39] North Dakota, 2004: 5.
[40] Texas, 2004: 12.
[41] Mississippi, 2003: 14.
[42] Mississippi, 2003: 14.

> *The actual date that rate changes were implemented in the old legacy system were not clearly identified through a review of on line screens making the validation of the correct payment difficult. The state should ensure that the actual date that rate changes that are implemented are captured and available online in the renovated MMIS system, Envision.*[43]

New York found it difficult to determine the payment amount for claims in which only a single claim line was available. In the cost and efficiency study interviews, a number of states pointed out the importance of examining claims through the lens of a contextual review. Some went so far as to consider this an absolute necessity in the medical review process.

> *Use of the Recipient Claim Detail Report provided a history of claims, by recipient, for the entire period surrounding the sample claim line. This history gave the reviewer a more complete picture and helped in the determination of the appropriateness and accuracy of the sample claim.*[44]

New York's comment about competing for the time of other staff touches on the administrative and staffing issues already brought up by states. However, the states also note that possible conflicts of interest may exist where program staff are responsible for payment accuracy in areas they are asked to review. Some other states have informally noted this in the past.

> *One issue was obtaining information from program staff, while examining payment accuracy for services in their area of responsibility, and competing with other priorities impacting their availability. The PAM staff utilized increased time and effort to obtain program/policy information and feedback necessary to analyze the accuracy of the payments.*[45]

Texas found it difficult to maintain inter-reviewer consistency, particularly with a staff large enough to review 3,421 claims. Many other states have informally noted that this was a difficult issue for them to contend with as well.

> *Some inconsistencies were noted during the quality reviews with the utilization review nurse's error code assignments and in some cases with specific review findings. This will be addressed in the Year 3 project by reinforcing the review and coding guideline training and performing the quality reviews concurrent with the utilization reviews.*[46]

E. Error coding

Even after completing a medical review, states had difficulties determining when an error had occurred and how it should be coded. States also struggled to improve accuracy rates by improving their response rates, but some states that have difficulty encouraging providers to participate in Medicaid have noted that they run the risk of potentially alienating providers and jeopardizing access if they impose too many administrative burdens. Some states also

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[43] Mississippi, 2003: 14.
[44] New York, 2003: 15.
[45] New York, 2003: 15.
[46] Texas, 2004: 12.

encountered difficulties incorporating their eligibility review errors into the overall payment accuracy rate.

Indiana expressed a number of problems coding errors throughout its study, most notably during its cost and efficiency study interview. While there is some opportunity for states to collaborate and share ideas on this topic, Indiana identified some state-specific issues that may require some subjective decisions.

> *Critical to this analysis is how an error is defined and then the subsequent logic used to determine whether that error constitutes an overpayment. It should be noted that this is a highly subjective process. For example, if a medical chart lacks parental approval and that is considered an error, does this constitute an overpayment? It is the consensus opinion of Indiana Medicaid that it does not. In most cases we have tried to identify examples that fall in this category as "opportunities for education". This subjectivity does however appear through the entire analysis. OMPP [Office of Medicaid Policy and Planning] is comfortable with the softer part of this project with the understanding that this is a pilot and any interpretation of the results should emphasize the nature of the effort. This data should not be combined or compared to another state because of the inconsistencies across the country in how errors were defined and interpreted.*[47]

Indiana also noted that claims with co-payments were troublesome. This issue was discussed extensively at the January 2004 conference in New Orleans, LA.

> *OMPP is evaluating whether policy and procedure clarification is required for certain claims subject to co-payments. Claims with multiple line items for components of services were identified where an applicable co-payment was deducted from one single line item as opposed to total services for the date of service. No errors were identified for this issue.*[48]

During its efficiency study interview and again in its Year 2 final report, Nebraska noted some difficulties it experienced assigning errors to claims. While an error hierarchy has been established, more defined guidance in this area would be helpful.

> *In some cases more than one error was identified per record reviewed. Since the medical reviewers were not responsible for determining the dollar amount in error, there was some confusion regarding how to report these errors. A decision was made to report potential "quality of care" errors in the "other" category even though a payment error was not associated with this error type. This resulted in a large number of medical errors reported during the first level review. There was difficulty in assigning some errors and a lack of consistency among reviewers. Nebraska would recommend clearer definitions of each category and an integration of processing and medical review findings.*[49]

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[47] Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning. "Payment Accuracy Measurement Demonstration Year 2: Fee-For-Service and Capitation Models," December 10, 2003: 9.

[48] Indiana, 2003: E-1.

[49] Nebraska, 2004: 5.

F. Eligibility review

The review of eligibility was new to Year 2 of the PAM project. While only six states chose to participate in eligibility reviews, their feedback was closely monitored throughout the process. The cost and efficiency study found that eligibility reviews were among the most costly and time-consuming part of the PAM project, even for a subset of 50 to 100 cases. In the Year 2 reports, states addressed a number of administrative issues involving budgeting sufficient staff time and accessing relevant information.

Florida found it difficult to incorporate eligibility errors into the final payment accuracy rates. Since error rates tended to be higher in the subsample selected for eligibility reviews, it was unclear whether the payment accuracy rate reported could be considered truly accurate if the eligibility errors were not extrapolated to the entire claims sample. Further, a large proportion of cases were dropped during the eligibility reviews because they could not be completed.

> *In terms of analysis, incorporation of the eligibility data into the error rate is problematic. Since eligibility reviews are such a small portion of the sample, they have negligible impact on levels of payment accuracy. This would be true even with a smaller managed care sample. However, for managed care, the eligibility error for the cases examined was higher than the rate of payment error. Eligibility error effects were further dampened by not including "unable to determine" in the error classification. "Unable to determine" was quite high at 14 percent of the sample in the eligibility determination arm.*[50]

Nebraska was one of six states that opted not to participate in the Year 2 eligibility review. Ultimately, it decided that staffing shortages and time delays would have been exacerbated by participating in the eligibility review.

> *Nebraska Medicaid in its proposal decided to not conduct eligibility reviews due to the additional staffing requirements, time constraints, and duplication of effort. It was determined that this would have resulted in an additional marked delay in completing the project requirements and additional costs for conducting the project.* [51]

Oklahoma found the eligibility reviews to be extremely costly and time-consuming. Most other states opting to participate in the project concurred. This at least partially explains why several Year 2 states decided against participation in Year 3 of the PAM project, in which 100 eligibility reviews were required.

> *Conducting the beneficiary eligibility review was resource intensive, both in the review and administratively, so much so that it does not appear that our sister agency will be able to conduct this review for us this year. They have conveyed to us that they would have to increase staff to perform the additional reviews. If they are unable to, this presents a monumental problem for us; the OHCA [Oklahoma Health Care Authority] does not have staff with eligibility review expertise.*[52]

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[50] Florida, 2003: 3.

[51] Nebraska, 2004: 5.

[52] Oklahoma, 2003: 2.

Texas' issues with eligibility reviews emerged from the fact that an entirely separate agency handles Medicaid eligibility in the state. Gaining access to eligibility information and software posed serious administrative hurdles and is likely to be an issue in other states as well.

> *The main problem encountered with the [managed care] study was getting security access to the TDHS [Texas Department of Human Services] eligibility and generic worksheet systems, and once access was received, getting the system software system to operate on our computer platform. System and policy training was readily provided by TDHS staff along with quick response to the project team and contractor's questions. A process was also needed for requesting the sample recipient's FFS claims from the billing and/or primary provider.*[53]

VII. NEXT STEPS AND CONCLUSIONS

A. Year 3 Model

On June 20, 2003, CMS released a solicitation for proposals from states interested in participating in Year 3 of the PAM project. The solicitation outlined a number of changes to the model, stemming in large part from the experience developed in Year 1 and Year 2 of the pilot project. Among the modifications are:

- Underpayments are to be added to overpayments when states calculate their final payment accuracy rates. In Year 2, underpayments were netted from overpayments.
- States are required to perform a review of eligibility for a subsample of 100 cases from their FFS and managed care studies where applicable (i.e., states executing both the FFS and managed care models will review 50 cases from each). In Year 2, the eligibility review was recommended but not required.
- A seventh stratum for Primary Care Case Management (PCCM) services was added for states in which this was a component of their FFS program. In Year 2, PCCM services were included within the independent practitioners/clinics strata.
- For the first time, the PAM project was expanded to include Title XXI State Children's Health Insurance Program (SCHIP) payments made for both stand-alone and expansion programs. As with Medicaid payments, states had the option of participating in the SCHIP pilot project for FFS, managed care, or both programs. (If states participate in Medicaid and SCHIP, 100 eligibility reviews are required for each program.)

A total of 27 states responded to the solicitation and submitted proposals to participate in Year 3 of the project. Their applications varied significantly from one another in terms of the combination of programs to be included in the study, and reflected the diversity of the states themselves. Table 10 lists the states that are participating in Year 3 and what programs they will be examining.

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[53] Texas, 2004: 16.

Table 10: State Participation PAM Year 3

State	Medicaid	SCHIP	SCHIP Type
Alabama		FFS	Stand alone
Arizona	FFS & MC	MC	Stand alone
Arkansas	FFS	FFS	Expansion
California	FFS & MC		
Colorado	FFS		
Delaware	FFS & MC	MC	Stand alone
DC	FFS & MC		
Florida	FFS	FFS & MC	Combo
Idaho	FFS	FFS	Expansion
Indiana	FFS & MC		
Iowa	FFS & MC	MC	Combo
Kentucky	FFS & MC		
Louisiana	FFS	FFS	Expansion
Massachusetts	FFS & MC	FFS & MC	Combo
Minnesota	FFS & MC		
New Mexico	FFS & MC	FFS & MC	Expansion
North Carolina	FFS	FFS	
North Dakota		MC	Combo
Oklahoma	FFS & MC	FFS & MC	Expansion
South Carolina	FFS		
South Dakota	FFS	FFS	Expansion
Texas	FFS & MC		
Utah	FFS	FFS	Stand alone
Virginia	FFS & MC		
Washington	FFS		
West Virginia		FFS	Stand alone
Wyoming	FFS		

State participation during Year 3 of the project will inform the design and implementation of a national payment accuracy program in the future.

B. Payment Error Rate Measurement (PERM) Implementation

CMS is currently drafting a federal regulation to implement a national system for payment error rate measurement.[54] According to the current timeline, a notice of proposed rulemaking will be

[54] Payment error rates are the inverse of payment accuracy rates: if a state found that 3 percent of claims were paid erroneously and 97 percent were paid accurately, it would report a 3 percent PERM rate and a 97 percent PAM rate.

issued in the summer of 2004, followed by a comment period. CMS plans to require all states to participate in PERM beginning in October 2005 (FY 2006).

A number of changes to the PAM model are being suggested when it is implemented nationally. Many of these will act upon the guidance issued by the OMB in response to the Improper Payments Information Act. For example, a review of eligibility will be performed for all claims sampled in conjunction with the project. Additionally, cross-over claims and Medicare Part B premium payments will not be excluded from the sample, as they were in the PAM pilot. Denied claims will also be included.

C. Conclusions

Payment accuracy rates, with standard errors, were calculated by all participants in the PAM Year 2 pilot project. The success of the PAM Year 2 pilot project can be measured by the increased number of participating states, the increased comparability of the studies across states with the development of the PAM model, and the flexibility of participating states to change course mid-year and incorporate modifications, such as the eligibility review, that strengthen the study results. Further, almost all elements of the PERM model, which will replace PAM, were tested successfully in Year 2.

APPENDIX A

STRATA DEFINITIONS FOR SAMPLING SERVICES

These service definitions correspond to the Medicaid Statistical Information System definitions.

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
- Primary care case management (PCCM) payments

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

APPENDIX B

PAM ERROR CODES AND HIERARCHY

The validation should consist of, at a minimum, two components: processing validation and medical review. It is recommended that the processing validation be performed first and that if errors are identified and payment was inappropriate for the line item then the second component – medical review is not performed. This approach may reduce the level of effort. The level of staff performing the processing validation is at the discretion of the state. It is recommended that Registered Nurses perform the medical review portion of the validation. Both over payment and under payment errors should be recorded.

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.

Medical Review Error Codes

1. MR1 – No documentation submitted – the line is unsupported due to no response to the documentation request.
2. 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.
3. MR3 – Coding error – the procedure was performed but billed using an incorrect procedure code.
4. MR4 – Unbundling – billing components of procedure codes when only one procedure code is appropriate.
5. 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.

6. 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.
7. 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.
8. 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% for processing reasons, there would be no requirement to request documentation for medical review of the claim or line item.