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PERM pearls: What CMS' Payment Error Rate Measurement data offers

By David R. Arday, MD, MPH, FACPM, CHCQM, Lisa A. Horst, BS, and Brenda Sue Watson, MLS, RHIA, CCS, CCS-P, CPC, CRC, CPMA

Medicaid program integrity has never been under as much scrutiny as it is right now under states' unwinding of autoenrollment imperatives of the Public Health Emergency.

Stakeholders use many tools to minimize negative impacts of noncompliance or inaccurate compliance with regulations, policies, and guidelines per redeterminations so that Medicaid and the Children's Health Insurance Program (CHIP) work as intended and for those who need it. It has widely been reported that roughly 10 million beneficiaries will no longer be Medicaid-eligible from the swells of the pandemic, yet the U.S. Department of Health & Human Services estimates that roughly 6.8 million will lose Medicaid coverage despite being eligible.[1]

One tool stakeholders can use to identify negative impacts of the massive administrative undertaking and to mitigate effects of current and new Administration policies in response to the COVID-19 pandemic is the Centers for Medicare & Medicaid Services' (CMS) Payment Error Rate Measurement (PERM) data. CMS has been using PERM since 2007 to help states improve accuracy of Medicaid and CHIP payments.

What is PERM

Medicaid and CHIP are among the states' largest expenditures. Combined federal and state contributions in fiscal year 2021 (recently available) totaled $734 billion for Medicaid and $22 billion for CHIP.[2]

With programs of this size, even small error rates can amount to billions of dollars in improper payments. Moreover, given the number of players involved in the program—states, hospital and health systems, professional providers, managed care entities, local health entities, patient stakeholder groups, and more—and the fact that state programs vary from one another, the programs inherently result in administrative errors and monetary losses due to those errors.

PERM helps reduce the number of administrative deficiencies and monetary losses in each state. Uniquely, 2022 is only the second year since program inception that CMS has reported publicly at the state level.[3] This data can be useful now.

Specifically, PERM produces statistically valid estimates of the amount of improper payments and monetary losses for each program every year. PERM's methodologies are complicated: Briefly, CMS contractors review a sample of claims paid in 17 states (including the District of Columbia) to assess errors in three areas:

- Eligibility
- Fee for service (FFS)
- Managed care

FFS claims are reviewed for adherence to federal regulations and state policies, and they undergo a medical record review. Managed care payments are subject only to the data processing review of adherence to federal regulations and state policies. The variance in methodologies consistently yields higher FFS improper payment rates than managed care rates: Current Medicaid FFS error rates are 10.42% versus 0.03% for managed care Medicaid error rates.[4]

CMS rolls the results from the current year plus the results of the two previous years from the other two 17-state cycles to a national improper payment rate. As previously cited, rates are also calculated for each state; states must submit corrective action plans to address the root causes of improper payments identified in their sample of claims.