DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #02-006

May 7, 2002

Dear State Medicaid Director

The Centers for Medicare & Medicaid Services (CMS) is pleased to solicit proposals from states interested in participating in the second year of the Medicaid Payment Accuracy Measurement (PAM) Project. As a Government Performance and Reporting Act (GPRA) goal, CMS has committed to assisting states in developing PAM methodologies, conducting pilot tests of alternative approaches, and exploring the feasibility of estimating payment accuracy for the Medicaid program at the national level. During the second year, CMS plans to expand the PAM Project by awarding grants to up to fifteen states to pilot test methodologies that have the potential to produce both state and national level estimates.

Working collaboratively with our technical consultant, The Lewin Group, and building upon the experiences of the nine states that have participated in the first year of the PAM Project, CMS has developed the CMS PAM Model for estimating payment accuracy in both the Medicaid fee-for-service and managed care programs. The CMS PAM Model contains a core set of required procedures to be implemented by the state during the project. States interested in pilot testing this model can also choose to implement various options in addition to the core requirements. States that elect to pilot test the core requirements of the CMS PAM Model, with or without options, will be given priority and will receive full Federal funding for all project costs.

Given the diversity among state Medicaid programs, developing a methodology that produces both state and national level estimates presents considerable challenges. Therefore, CMS is also interested in pilot testing a limited number of alternative methodologies that offer unique and innovative contributions to the PAM Project. Importantly, CMS will only approve alternative methodologies from states that significantly advance our efforts to produce state and national level estimates. Consequently, the burden rests with the state to show that the proposed alternative will likely improve upon the core requirements of the CMS PAM Model. States that elect to pilot test alternative methodologies will only be partially funded for project costs.

As in the first year, state participation in the PAM Project will be supported through a combination of Federal financial participation (FFP) and Health Care Fraud and Abuse Control (HCFAC) grant funding as reimbursement for the state share. For the second year, CMS has slightly more than $2 million in HCFAC funds to support state PAM Projects. At least ten of the fifteen awards will be made to states that pilot test the core requirements of the CMS PAM Model, with or without options; no more than five of the awards will be made to states that propose pilot testing alternative methodologies. States will report PAM Project costs up to the

CMS approved budget ceiling as regular Medicaid administrative costs, and receive FFP in those expenditures. For states that pilot test the core requirements of the CMS PAM Model, with or without options, CMS will reimburse with HCFAC funds all of what would normally be the state share of PAM Project costs. However, given the limited HCFAC funding, CMS can only partially fund up to five states that develop and pilot test alternative methodologies; HCFAC funding will be limited to 50 percent of what would normally be the state share of total project costs. Accordingly, states proposing alternative methodologies will receive the full FFP share plus 50 percent of what would normally be the state share, or at least 75 percent of the total project costs.

Applications for the second year of the PAM Project beginning September 30, 2002 are due 45 days from the date of this letter. Applications may be submitted by the state Medicaid agency or other state agencies in partnership with the Medicaid agency. During the second year of the PAM Project, CMS plans to expand the scope of the demonstration to up to fifteen states. Second year participation is open to all states, regardless of participation in the first year of the demonstration. States that participated in the first year of the PAM Project must submit a new application to participate in the second year. CMS anticipates announcing the awards within 45 days of receiving the applications.

CMS encourages your participation in the second year of the PAM Project. Improper payments are a problem receiving growing attention at both the state and Federal levels. In the Medicaid program, improper payments diminish vital program dollars affecting both beneficiaries and taxpayers. Consequently, the Federal Government and the states have a strong financial interest in assuring accurate payments. Due to the fact that no systematic means of measuring payment accuracy at the state and national levels currently exists, we must work in partnership to develop promising methodologies that will better identify our program vulnerabilities and help target our corrective actions.

The Program Announcement is enclosed. If you have any questions or need additional assistance, please contact the PAM Project Officer, Wayne A. Slaughter at (410) 786-0038 or email: wslaughter@cms.hhs.gov.

I look forward to joining with you to enhance the effectiveness of the Medicaid program. Our success will be in meeting the needs of our beneficiaries while better ensuring the financial integrity of the program.

Sincerely,

/S/

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

State Program Integrity Directors

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director
Association of State and Territorial Health Officials

Jim Frogue
Acting Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Mathews
Senior Health Policy Analyst
Council of State Governments

Executive Summary

Medicaid Payment Accuracy Measurement (PAM)
Demonstration Project
CFDA – 93.779

The Centers for Medicare & Medicaid Services (CMS) is soliciting proposals from states to participate in the second year of the Medicaid PAM Project. Health Care Fraud and Abuse Control (HCFAC). Grant funding has been procured for the second year that enables CMS to expand the PAM Project to up to fifteen states. The purpose of the second year of this cooperative agreement is to further develop, refine, and pilot test methods to measure the accuracy of Medicaid payments at the state and national levels.

During the first year of the PAM Project, nine states were funded by CMS to develop and pilot test methodologies that would produce state-specific payment accuracy estimates. These methodologies have provided CMS with a number of diverse approaches to measuring Medicaid payment accuracy at the state level. Incorporating best practices from these nine pilot projects, and groundbreaking efforts previously implemented by states such as Illinois, Texas, and Kansas, CMS has developed the core requirements for the CMS PAM Model. This model has been designed to produce both state and national level estimates, providing CMS with both the uniformity and precision to report payment accuracy estimates across the Medicaid program at the national level, while maintaining sufficient flexibility to enable states to produce state-specific estimates. During the second year of the demonstration project, CMS intends to prioritize pilot testing this model. However, recognizing that payment accuracy measurement is a developing science, CMS is also interested in pilot testing a select number of innovative alternatives to this model.

In the second year of the PAM Project, CMS will fund up to fifteen states. CMS will pay 100 percent of the project costs for at least ten states that pilot test the core requirements of the CMS PAM Model with or without options; the core requirements and options are detailed in Section III E. Program Announcement. States electing to pilot test the core requirements of the CMS PAM Model may also propose to pilot test options not identified by CMS. However, these options must add to the value of the model without compromising the core requirements. CMS recommends that states proposing to pilot test the CMS PAM Model include both fee-for-service and managed care models in their proposals; this is only applicable among states where each constitutes at least 10 percent of the state's Medicaid program by dollar volume.

In addition, CMS intends to partially fund up to five states to develop and pilot test innovative alternative methodologies. For these states, grant funding will be limited to 50 percent of the state share of total project costs. Therefore, states proposing alternative methodologies will receive the full Federal financial participation (FFP) share plus reimbursement for 50 percent of the state share; as a result, CMS will fund at least 75 percent of the total project costs in these states. Importantly, states that elect to pilot test alternative methodologies must show that the proposed alternative will likely improve upon the core requirements of the CMS PAM Model. CMS will only fund alternative methodologies that significantly advance our efforts to produce state and national level estimates. These alternative methodologies must offer innovative

approaches to measuring payment accuracy that are not represented in the core requirements of the CMS PAM Model. Therefore, CMS recommends that states proposing alternative methodologies also indicate their willingness to pilot test the CMS PAM Model, with or without options. In the event the alternative methodology is not approved, these states may be given an opportunity to submit a proposal to pilot test the CMS PAM Model.

This solicitation is for the second year of the PAM Project. Applications are due no later than June 20, 2002, which is 45 days from the date of the solicitation. Only one application will be accepted from each state. States currently participating in the first year of the PAM Project are encouraged to apply for the second year. Applications will be accepted from the state Medicaid agency or from another relevant state agency (e.g. Auditor, Comptroller) if working in collaboration with the Medicaid agency. Proposals are being solicited under the authority of section 402(a)(l)(J) of the Social Security Act Amendments of 1967. For purposes of this cooperative agreement, "state" is defined as each of the 50 states and the District of Columbia.

CMS anticipates announcing the awards within 45 days of receiving the applications. The funding period is for 12 months from September 30, 2002 through September 29, 2003.

Medicaid Payment Accuracy Measurement (PAM)
Demonstration Project
CFDA – 93.779

Sponsored by:
The Centers for Medicare & Medicaid Services

I. Purpose

The Centers for Medicare & Medicaid Services (CMS) is soliciting proposals from states to participate in the second year of the Medicaid PAM Project. This grant offers the opportunity to work collaboratively to further develop, refine, and pilot test methods to measure the accuracy of Medicaid payments at the state and national levels. To be eligible for selection, the state must be either the state Medicaid agency or a state agency working in partnership or agreement with the state Medicaid agency.

The Medicaid program spends $225 billion taxpayer dollars annually on services for eligible beneficiaries. The taxpayer dollars invested in the program must be managed and expended for needed services at reasonable rates. 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. CMS has been urged by Congress, the GAO, OMB, OIG, and others to establish a method to measure the accuracy of Medicaid payments. Essentially, payment accuracy measurement enables government to: (1) identify the extent of problems in the payment system; (2) study causes; and (3) strengthen internal controls. CMS has committed to working collaboratively with the states to develop a methodology that meets these criteria.

As a result of contributions from the nine states participating in the first year of the PAM Project, CMS and its consultant, The Lewin Group, have developed the CMS PAM Model that will be pilot tested during the second year. This model has the potential to measure the accuracy of Medicaid payments at both the state and national levels. States participating in the second year of the PAM Project will function as members of the demonstration team. The team members will include Project Directors from the fifteen states, CMS staff, The Lewin Group and its subcontractors. The goals of the team will be to: 1) pilot test the CMS PAM Model in at least ten states; 2) pilot test innovative alternative methodologies in up to five states; 3) pilot test optional strategies and practices that will improve the PAM Project; and (4) help CMS effectively identify and resolve the various impediments and challenges to implementing Medicaid payment accuracy measurement methodologies at the state and national levels.

II. Background

The Centers for Medicare & Medicaid Services is soliciting State Medicaid Directors to participate in the second year of the Medicaid PAM Project. CMS has committed to assisting states in developing PAM methodologies, conducting pilot tests of alternative approaches, and exploring the feasibility of estimating payment accuracy for the Medicaid program at the national level. During the second year, CMS plans to expand the PAM Project by awarding

grants to up to fifteen states to pilot test methodologies which have the potential to produce both state and national level estimates.

The Medicaid program currently spends over $225 billion taxpayer dollars annually on services to eligible beneficiaries; however, the magnitude of improper payments throughout the program in unknown. During the past several years, three states have attempted to estimate the percentage of Medicaid dollars lost to improper payments at the state level through innovative payment accuracy studies.

- The Illinois Department of Public Aid conducted a payment accuracy study in 1998; this study was based upon a stratified sample of 599 Medicaid services paid during one month. The study enabled Illinois to estimate a payment accuracy rate of 95.28 percent for the Medicaid program and succeeded in further identifying problem areas and targeting corrective actions.
- Texas completed a Health Care Claims Study in 1998 using a total random sample of 1,200 patient days, 700 of which were patient days from the Medicaid program. From the study, the Comptroller reported overpayments of 6.8 percent with a corresponding payment accuracy rate of 93.2 percent for the state's Medicaid program. In a follow-up Health Care Claims Study two years later, Texas estimated a slight increase in overpayments resulting in an accuracy rate of 92.8 percent for the Medicaid program.
- In 1999, Kansas reviewed 600 paid claims drawn from one month in a stratified random sample. Although the overall payment accuracy rate was 76 percent, after controlling for insufficient or absent documentation, the payment accuracy rate for the Medicaid program increased to 91 percent.

Building upon these pioneering state-specific Medicaid studies and the annual CFO Audit claims review of the Medicare program conducted by the Office of Inspector General, CMS established a work group to help develop a Medicaid payment accuracy study. In July 2001, CMS formally solicited State Medicaid Directors to participate in the first year of the Medicaid PAM demonstration project. Using a combination of Federal financial participation (FFP) share and special grant funding from the Health Care Fraud and Abuse Control (HCFAC) program, nine states were awarded grants to develop and pilot test a variety of state-specific payment accuracy methodologies. Participating states received reimbursement for 100 percent of the total first year PAM Project costs.

For the second year, CMS is expanding the PAM Project to include up to fifteen states. During the second year, at least ten of the fifteen states will pilot test the CMS PAM Model. The model is designed to produce Medicaid payment accuracy estimates at both the state and national levels. Additionally, up to five of the fifteen states will receive partial grant awards during the second year to develop and pilot test innovative alternative payment accuracy methodologies.

III. Demonstration Project: Second Year

This solicitation is for the second year of the Medicaid PAM demonstration project. In the second year, the goal is to test an explicit model for payment accuracy measurement of both fee-for-service and capitated managed care programs.

A. Who May Apply

Applications will be accepted from two types of agencies: 1) the state Medicaid agency; or 2) the Auditor, Comptroller or other state agency, in partnership with the state Medicaid agency. Second year participation is open to all states, regardless of participation in the first year of the demonstration. States that participated in the first year of the PAM Project are encouraged to submit an application to participate in the second year.

For the purpose of this cooperative agreement, "state" is defined as each of the 50 states and the District of Columbia. Only one application will be accepted per state. See Part VI for specific information regarding the application process.

B. Duration of Awards

The award is for the second year of the Medicaid PAM Project beginning September 30, 2002 and ending September 29, 2003.

C. Amounts and Timelines for Funding

CMS anticipates announcing the awards within 45 days of receiving the applications. Applications are due no later than June 20, 2002, which is 45 days from the date of the solicitation. The funding is for the period of September 30, 2002 through September 29, 2003. State participation in the PAM Project will be supported through a combination of FFP and HCFAC grant funding as reimbursement for the state share. For the second year, CMS has slightly more than $2 million in HCFAC funds which will support just over $4 million in total state PAM spending.

At least ten of the fifteen awards will be made to states that pilot test the core requirements of the CMS PAM Model, with or without options; no more than five of the awards will be made to states that propose pilot testing alternative methodologies. CMS will pay 100 percent of the project costs for states that pilot test the core requirements of the CMS PAM Model, with or without options. However, due to HCFAC funding constraints, CMS can only partially fund up to five states to develop and pilot test alternative methodologies; for these states, grant funding shall be limited to 50 percent of the state share of total project costs. Accordingly, states proposing alternative methodologies will receive the full FFP share plus reimbursement for 50 percent of the state share; as a result, at least 75 percent of the total project costs for these five states will be funded by CMS.

The authority for this project is provided for under section 402(a)(l)(J) of the Social Security Act Amendments of 1967. States will report project costs up to the approved funding ceiling on the quarterly Medicaid expenditure reports (Form CMS – 64.10) at the applicable match rate (normally 50%), and receive the Federal share through the standard grant award and draw down process. The HCFAC special grant funds will be paid through a separate draw down account established for that purpose. The detailed financial proposal accompanying the application must demonstrate an understanding of the funding mechanism.

D. Uses of Funds

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

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

E. Program Announcement

CMS has developed PAM Models for both fee-for-service and capitated managed care. These models contain the essential features necessary for building a state and national payment accuracy measure. Respondents are encouraged, but not required, to include both fee-for-service and capitation managed care models in their proposals if each constitutes at least 10 percent of the state's Medicaid program by dollar volume.

The purpose of the second year pilot project is to test these models. Section 1 describes the fee-for-service CMS PAM Model and Section 2 describes the capitation managed care CMS PAM Model. Section 3 describes the requirements for proposals to use alternative methodologies.

There are various options in addition to the core requirements of the CMS PAM Model. Within each model, some optional elements are explicitly identified. When those features are described, they will contain the word "options" or "optional" as they are introduced. The state may propose to include some, all, or none of these optional elements in its project. In addition, the state may propose optional elements that are not explicitly identified below. In either case, the optional elements included should be *in addition to* the features of the core model(s). That is, the accuracy measure should be produced as specified under the core requirements of the model. The optional features may result in additional reporting formats, etc., but all of the information in the core requirements of the CMS PAM Model must also be included.

If the state proposes optional features, it should: (1) indicate why the additional features are desirable; (2) identify the cost of the optional features in its cost proposal; and (3) describe how

the state will evaluate the "value added" of the optional feature as part of its demonstration project. The state is neither encouraged nor discouraged from proposing optional features.

There are limited funds available for the demonstration project. Proposed options will be selected for inclusion based on the potential value added of the optional feature and its cost. CMS reserves the right to accept a state's proposal but to choose not to fund any or all optional features proposed. In all cases, the optional features are in addition to the core requirements of the CMS PAM Model, not in lieu of them.

Finally, a limited number—no more than five of fifteen planned state pilot projects—may be awarded for proposed payment accuracy measurement methodologies that are alternatives to the CMS PAM Models. If the state proposes an alternative methodology, in its proposal it should: (1) clearly describe the alternative and how it results in a payment accuracy measure; (2) discuss the strengths and weaknesses of the proposed alternative and, in particular, indicate how the alternative is an improvement over the CMS PAM Model; and (3) describe how the alternative might be applied generally across all the states and be capable of producing a national payment accuracy measure. As noted earlier, states proposing alternative methodologies will receive the full FFP share plus reimbursement for 50 percent of the state share; as a result, at least 75 percent of the total project costs for these five states will be funded by CMS.

1. Payment Accuracy Measurement Model: Fee-for Service Claims

The CMS PAM Model for Medicaid fee-for-service payments to providers is straightforward. Moreover, it is one that has precedent in the measures applied by Illinois, Kansas, and Texas in their respective Medicaid programs.[1] In addition, the Office of the Inspector General, Department of Health and Human Services, and the CMS Comprehensive Error Rate Testing (CERT) program in Medicare have applied similar measures to Medicare payments.[2]

The basic payment accuracy measurement concept is:

- draw a random sample of claims from the universe of all paid Medicaid claims in the state;
- subject that sample to review and audit to determine the validity of the payments made; and
- compute an accuracy rate based on the sample, where the accuracy rate is defined as the ratio of the expected dollar value of payments paid accurately to the dollar value of total payments made.

[1] Illinois Division of Medical Programs, Office of the Inspector General. *Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement.* 1998; Kansas Medical Policy Department, Social and Rehabilitation Services, *Payment Accuracy Review of the Kansas Medical Assistance Program*. April 2000; Texas Comptroller of Public Accounts, *Texas Health Care Claims Study*, *2000*, January 2001.

[2] Office of the Inspector General, *Improper Fiscal Year 2000 Medicare Fee-For-Service Payments*, February 2001. A-17-00-02000; Hogan, P.F., Browning, N., Simonson, B., *CERT Error Rate: Estimator, Standard Error and Sampling Plan,* November 20, 2000.

Key Components and Parameters

Below, we further define the key parameters of the fee-for-service payment accuracy measure.

Universe

The "universe" of claims is the set of claims from which the sample is drawn, and the set of payments for which the accuracy rate is inferred from the sample. The Medicaid fee-for-service claims universe, from which the sample is to be drawn, consists of all fee-for-service Medicaid claims *paid* to providers for which there is Federal financial participation. That is, if the Medicaid service relevant to the claim is paid for, in part or in whole, by Federal dollars, the claim should be included in the universe or population of claims to be sampled.[3] It excludes any non-service based payments such as disproportionate share payments, crossover claims, aggregate cost settlement payments, payments made by Medicaid to Medicare for Medicare Part A or B insurance, capitation payments, and any other expenditure that is not a payment to a provider for services provided to a beneficiary or recipient. It includes only payments made to providers of services. An exception to this is that it will also include payments made to providers under primary care case management (PCCM). The universe will consist of paid claims only; those denied or returned to a provider because of submission errors will not be sampled.

Time Period for Sampling

The sample shall be drawn from a universe of all claims paid over the first quarter of the Federal fiscal year. That is, all paid claims for which payment was made between October 1, 2002 and December 31, 2002, inclusive, will be included in the universe for sampling purposes. The inference drawn from the sample regarding the payment accuracy rate, however, will be for the entire Federal fiscal year, October 1, 2002 through September 30, 2003.

Sampling Unit

The sampling unit will be the "line item" or service. While an actual claim may consist of several line items or services, as long as these line items can be independently priced, they will constitute the sampling unit. [Items simply listed as included in a bundled service would not be considered "line items" for this purpose. For example, if inpatient claims are paid on the equivalent of a diagnosis related groups (DRG) payment, the DRG would constitute the line item for sampling purposes. If inpatient claims are paid on a per diem basis, a line item might be "five days." In this case, the item five days would count as one item and not five.]

It is assumed that the state can sample at the "line item" or service level, and sample sizes and sampling plans are predicated on sampling at the line item level. If the state can draw samples only at the "claim" level—the submission by the provider with one or more line items on it—the state may select and review all line items on the claims sampled. However, for sample size

[3] States may sample from either a paid claims universe, or from a universe of claims which have been fully adjudicated for payment, and for which the State has determined a liability to reimburse the provider.

purposes, the claim itself will count only as one sampling unit, regardless of the number of items reviewed on the claim.[4]

Sampling Plan

The overall sample size will be drawn to obtain an estimate of the accuracy rate that is within ± 3 percentage points of the true population accuracy rate, with 95 percent confidence. We anticipate that sample sizes necessary to achieve this level of precision will typically be *greater than* 800 line items. For example, if all line items had the same dollar value—which is not the case—we could use a binomial distribution to calculate the required sample size. If we further assume a "worst case" accuracy rate of 70 percent (0.7), a sample size of 900 line items would be required to achieve the desired precision.[5]

A proportional, stratified random sample will be drawn. The sampling strata will be by major provider categories defined as:

- inpatient hospital services;
- long term care services;
- independent practitioners and clinics;
- prescription drugs;
- home and community-based services; and
- other services and supplies.

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

The sample sizes by stratum should be proportional to the dollar value of the line items represented by each stratum for the most recent four quarters.[6] That is, if inpatient hospital services represent 30 percent of the dollar value of total Medicaid claims, 30 percent of the sample of line items should come from the inpatient stratum. Note that this will result in

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

[5] Note that, in this very simplified binomial case, the sample size necessary to estimate the accuracy rate within 3 percentage points of the true rate with 95% confidence is $n = pq/(.03/1.96)^2 = 896$, where p is the accuracy rate and q is one minus the accuracy rate. In general, the required sample size will be greater than this because there is variation in the dollar value of line items that must be taken into account.

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

oversampling in strata for which the proportion of Medicaid payments is greater than the proportion of Medicaid line items, and undersampling in those strata for which the proportion of line items is greater than the proportion of Medicaid payments. When calculating the payment accuracy rate, this oversampling and undersampling by strata must be taken into account in calculating an unbiased estimate of the overall payment accuracy rate.[7]

Sampling Plan Options: As an option, the state may propose larger sample sizes within strata to obtain more precise estimates of the accuracy rate within a particular stratum. In addition, the state may propose additional strata (with larger sample sizes, if desired) to obtain precise estimates of the accuracy rate for a particular service or group of services. Costs for the proposed additional sample size and/or strata should be broken out separately. The potential advantages of the additional sample size and/or strata should be described and a plan for assessing the value of the additional sample size and/or strata should be included. The additional strata should not prevent the state from reporting results by the original strata. Sample sizes within the original strata should be at least as large as they would have been without the options.

Audit and Review

The review and audit should consist, at a minimum, of two components: processing validation and medical review.

Processing Validation

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

- duplicate item (claim);
- non-covered service;
- service covered by MCO (i.e., beneficiary is enrolled in managed care organization that should have covered the service)[8];
- third party liability;
- invalid pricing (including unbundling of bundled services);

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[7] 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.

[8] If the state has a non-enrollment capitated program, reviewers should determine whether that sample contains claims that fall within classes of services not explicitly excluded from payment under the terms of the capitated non-enrollment program. A "capitated non-enrollment option" is defined as a program under which a state makes a capitation payment to a managed care vendor to furnish a specified scope of services, such as behavioral health services, to all beneficiaries falling within a particular class, without requiring individuals to actively enroll with the contractor to receive services. Each claim for a service that is determined not to be explicitly excluded from coverage under a state's capitated non-enrollment program(s) should be reviewed to determine whether that claim should have been paid by a contractor. If it is determined that a claim should not have been paid by the fee-for-service claims processing system, the full amount of the claims should be reported as an inaccurate payment.

- logical edits (e.g., incompatibility between gender and procedure); and
- other.

When errors are found, the dollar amount of the payment error and the reason for the error should be recorded (to be included in the report). Reasons for error include:

- duplicate item;
- non-covered service;
- MCO coverage of service;
- third party liability;
- pricing error;
- logical edit; or
- other.

Medical Review

In addition, the line item should be subject to comprehensive medical review. Comprehensive medical review, as used here, will include at a minimum:

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

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

When errors are found, the dollar amount of the payment error and the reason for the error should be recorded (to be included in the report). Reasons for error include:

- unsupported due to non-response to documentation request;
- unsupported due to insufficient response to documentation request;
- medically unnecessary service;
- coding error; or
- other.

Draft Review Guidelines. Draft guidelines for medical review are included at Appendix B. ***The state is not required to adhere to those guidelines.*** However, in your proposal, please comment

briefly on the degree to which your own medical review procedures will be consistent with these general guidelines and indicate where they are likely to deviate.

Note that underpayments are not counted for the purposes of this study and should not be used to offset overpayments when calculating the accuracy rate.

Audit and Review Options: Additional audit and review activities may be proposed. Specific options include:

- beneficiary (recipient) surveys or interviews to confirm services;
- on-site review of medical documentation to ensure its integrity;
- contextual reviews of medical claims that consider line items in the context of a broader medical history; and
- error reporting by additional (or different) categories of errors.

Costs for any proposed optional review and audit activities should be broken out separately. The advantages of proposed options should be discussed, along with a plan for evaluating the additional benefits provided by the optional activities, should they be implemented. The optional activities should be in addition to the audit and review items of the core requirements of the CMS PAM Model. (Exceptions to this are cases when the option clearly expands the basic activity, such as an "on site" review of medical records documentation rather than a letter request for review.)

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

The payment accuracy rate can be computed in two ways. The first method, a ratio estimate, is computed as the ratio of the total dollar amount of sampled line items paid accurately to the total amount paid to providers for those line items. If, upon review, the payment of a line item is reduced, but not fully denied, the reduced amount (which is the accurate portion of the payment) appears in the numerator.

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

$$AccuracyRate = \frac{\sum_{j=1}^{K} \sum_{i=1}^{n_j} w_j p^{A}_{,i,j}}{\sum_{j=1}^{K} \sum_{i=1}^{n_j} w_j p^{M}_{i,j}}$$

where P^A is the dollar amount of the i^{th} paid line item in stratum j that was paid accurately and P^M is the total amount of the item that was paid to a provider for the i^{th} line item in stratum j. The Wj's are the relevant weights for the strata applied to the items to account for oversampling and undersampling. These weights, for each stratum, will be the ratio of the proportion of line

items in the universe in that stratum to the proportion of line items in the sample represented by that stratum. The sample size is n, overall, with n_j line items in stratum j.

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

$$TotalEstimatedAccuratePayments = \frac{\sum_{j=1}^{K} \sum_{i=1}^{n} w_j p_{i,j}^{A}}{F}$$

Then, the accuracy rate is equal to:

$$AccuracyRate = \frac{TotalEstimatedAccuratePayments}{TotalPayments}$$

Note that the "total estimated accurate payments" is an estimate, based on the sample of n line items, of the total dollar value of accurate payments made for the universe, and "total payments" are the total payments made to providers in the universe for that period. The standard error and 95 percent confidence interval should be computed for the estimated payment accuracy rate. We recognize that the assumptions underlying the computation of sample size required to achieve the desired level of precision may be not be realized in the actual sample drawn. Hence, the actual confidence interval calculated for the estimated payment accuracy rate may be different from the ± 3 percent interval desired. However, the assumptions used in calculating the sample size should be conservative so that is likely that the actual confidence interval will be ± 3 percentage points or smaller.

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

Reporting

In reporting the estimated payment accuracy rate, the following information should be provided:

- the payment accuracy rate;
- its standard error and 95 percent confidence interval;
- point estimates of rate by stratum;
- total sample size and sample size of each stratum, measured by both number of items and dollar value;

- proportion of dollars and proportion of items represented by each stratum, both in the universe and in the sample;
- dollar distribution of errors by reason; and
- findings and observations resulting from the analysis.

CMS will provide specific guidelines for final reports to ensure that findings are reported consistently across states.

Reporting Options: The respondent may propose alternative ways of reporting results, including:

- alternative error categories;
- standard errors and confidence intervals within strata;
- alternative strata; and
- statistical tests of differences between strata.

However, results must also be reported according to the CMS PAM Model's core requirements. In addition, if there are any additional costs associated with the proposed reporting options, these costs should be broken out separately.

2. Payment Accuracy Measurement Model: Capitated Managed Care

Unlike the fee-for-service CMS PAM Model, there are few precedents upon which to build a managed care payment accuracy measurement model. The core requirements of the capitation CMS PAM Model presented below, however, are conceptually similar to the fee-for-service model:

- "claims" (managed care capitation payments or other payments paid to managed care organizations for a specific beneficiary) are sampled;
- sampled payments are then subject to validation; and
- the payment accuracy rate is computed as the ratio of accurate payments made to total payments made.

Key Components and Parameters

Universe

Each state enrolling beneficiaries in fully or partially capitated managed care health plans should include transactions determined by such arrangements within the scope of its payment accuracy measurement program. That includes monthly capitation payments and any additional payments made to managed care organizations (MCOs) for qualifying events, e.g., additional payments made for maternity cases. Monthly management fees paid to primary care physicians under a primary care case management (PCCM) program are not considered "capitation payments" for

the mandatory part of the managed care model. Rather, they are included in the FFS stratum: "independent practitioners and clinics."

The "universe" is the set of payments for which the accuracy rate is inferred from the sample. The Medicaid capitation payments universe, from which the sample is to be drawn, consists of those payments described below, for which there is Federal financial participation, that are *paid* to MCOs and providers.

Universe Options: The state may propose to expand the universe of payments sampled. In particular, it may propose to include PCCM monthly management fees (not the associated service costs) in its capitated managed care sample rather than in the FFS stratum: "independent practitioners and clinics." Costs for including the proposed additional payments to be included in the universe and sampled as part of the project should be separately broken out in the cost proposal. The potential advantages of including the additional payment types should be described and a plan for assessing the value should be included. The additional payments should not result in a reduction in the sample size or precision for the estimation of the accuracy rate from the universe defined in the core requirements of the CMS PAM Model, and results should be reported separately for the universe defined by the model and the expanded universe.

Time Period for Sampling

The sample shall be drawn from a universe of all managed care capitation claims paid (and PCCM management fee payments if included as an option) over the first quarter of the Federal fiscal year. That is, all paid claims for which payment was made between October 1, 2002 and December 31, 2002, inclusive, will be included in the universe for sampling purposes. The inference drawn from the sample regarding the payment accuracy rate, however, will be for the entire Federal fiscal year, October 1, 2002 through September 30, 2003.

Transactions involving monthly capitation payments made on behalf of beneficiaries enrolled in health plans should be sampled directly, as described in section entitled "Capitated Premium Payments" below. Transactions involving fee-for-service claims that are paid on behalf of beneficiaries who are enrolled in capitated managed care will be assessed as described in the section entitled "Payment of Fee-for-Service Claims for Managed Care Enrollees" below.

Capitated Premium Payments

Sampling of Capitation "Claims"

States should treat a claim for a capitation payment made on behalf of an individual beneficiary for an individual month (or partial month) and any additional payments made under the managed care arrangement for a qualifying event, e.g. a delivery, as a sampling unit for payment accuracy measurement. Only capitation transactions and other invoices actually paid by the state should be sampled. Capitation line items presented on rosters (or other media) by health plans to the states that were not actually paid during the sampling period should be excluded from the sampling frame.

The sample of capitation claims should be determined independently from the fee-for-service claims sample, and should be drawn to obtain an estimate of the accuracy rate that is within 3 percentage points of the true population accuracy rate for capitation payments, with 95 percent confidence.

Figure 1 below illustrates the sampling frame.

Figure 1

Sampling Options: The state may propose to stratify the sample by strata of policy interest, such as by MCO, and increase the sample size to obtain more precise results within strata. Costs for including the proposed additional strata and sample size should be separately broken out in the cost proposal. The potential advantages of including the additional strata and sample size should be described and a plan for assessing the value should be included. The additional strata and sample size should not result in a reduction in the sample size or precision for the estimation of the accuracy rate defined in the core requirements of the capitation CMS PAM Model. Moreover, results should be reported separately for the model without the additional strata and the model with options.

Audit and Review of Capitation Claims

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

Appropriateness of Capitation Payment

For each capitation claim or other payment drawn for payment accuracy measurement, reviewers must obtain information from the state's original managed care eligibility and enrollment transaction records that is sufficient to determine whether payment should have been made by the state to that specific health plan on behalf of that specific beneficiary for that specific month.

While the exact criteria under which proper enrollment is determined will require assessment of state-specific rules governing such transactions,[9] the critical questions are:

- Was that specific beneficiary eligible to be enrolled in *any* capitated managed care arrangement in that month?
- Was the beneficiary eligible to be enrolled in that specific health plan in that month?
- Was the beneficiary actually enrolled in the health plan for that month, and eligible to receive services?[10]

Reviewers should analyze the information available from managed care eligibility and enrollment transaction records and make an independent determination of whether that enrollee was eligible to be enrolled, and was actually enrolled, in a specific health plan in the month in question. If that determination confirms the appropriateness of the beneficiary's enrollment in that plan in that month, further assessment of the capitation payment amount should be conducted under the procedure described in the following section. If the eligibility and enrollment determination made by reviewers contradicts the appropriateness of payment to that plan for that beneficiary for that month, the full amount of that monthly capitation payment should be determined to be an inaccurate payment.[11] To determine the accuracy of additional payments made to the MCO, reviewers may need to review additional documentation, such as medical records.

Accuracy of Payment for Properly-Enrolled Beneficiaries

For each capitation or other payment that is determined under the procedure described above to have been made for a beneficiary who is properly enrolled in that plan for that month, reviewers should make a determination regarding the appropriate amount of payment that should have been made on that beneficiary's behalf. Employing the managed care eligibility and enrollment information gathered in making the determination of appropriate enrollment, reviewers should make an independent determination of the specific capitation payment rate cell that should have been applied to that beneficiary's enrollment with that plan in that month, and the dollar amount that was appropriate for that rate cell.[12]

If the state's capitation plan includes variation in payment based on medical or other criteria, the review should attempt to verify that the beneficiary has met the criteria. The reviewer should have sufficient clinical background to make this determination, should the payment system be based on clinical criteria. States that assign individuals to specific rate cells based on diagnosis

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[9] For example, in some states eligibility for managed care enrollment can vary depending on the place of residence or eligibility status of the beneficiary, or eligibility for enrollment in specific health plans may be restricted to a subset of the population eligible for enrollment in other health plans.

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

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

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

should review records from the same sources and time period as the data used in the cell assignment algorithm (e.g., from the FFS provider if FFS data was used, or from the MCO provider if encounter data is used). In this way, the state can verify that the payment category assigned by the risk adjustment algorithm is supported by the beneficiary's medical record.

The amount determined to be the accurate payment amount should be compared to the amount of the actual payment recorded in the sampled transaction record. If an overpayment was made, the amount of any difference between the determined amount and the actual amount should be recorded as an inaccurate payment. Note that underpayments are not counted for the purposes of this study and should not be used to offset overpayments when calculating the accuracy rate.

Audit and Review Options: The state may propose additional validation methods or procedures for the capitation payments. A clear link between the additional validation and the payment accuracy measure should be established. For example, simply stating that encounter data will be validated, without establishing how this will affect the accuracy rate, is not acceptable. The cost of any options proposed must be broken out separately. The potential advantages of including the validation methods or procedures should be described and a plan for assessing the value should be included. The additional validation methods or processes should not substitute for the core requirements of the CMS PAM Model. Results should be reported separately for the model without the optional features and the model with options.

Payment of Fee-for-Service Claims for Managed Care Enrollees

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

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

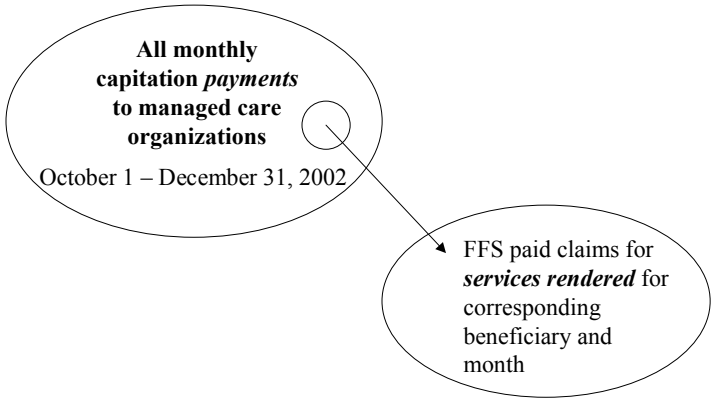
(The fee-for-service claims that were erroneously paid to managed care enrollees are based on the capitation managed care sample. Hence, any inferences regarding the total errors made for the universe must be made based on an inference from the managed care side. It would be incorrect to simply include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

managed care plan. However, it should report the number and dollar value of any such errors separately, and not include them directly in the managed care payment accuracy measure.)

Determination of Claims for Review

The state is required to evaluate fee-for-service claims paid for services incurred during the month of enrollment for each enrollee determined, in the capitation payment review conducted above, to be properly enrolled in a health plan for that month.[13] Reviewers should obtain from the state's paid claims history all of the fee-for-service paid claims for services *incurred* on behalf of the sampled beneficiary during the enrollment month. The state should review all paid claims for services incurred during this period, even if the claim was not paid until after the end of the period. Figure 2 illustrates this.

Figure 2



Determination Regarding Duplication of Coverage

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

Where a determination regarding contractual coverage turns on clinical issues, that determination should be made based on a medical record review process. If the review supports a determination that the claim was, in fact, covered within the scope of a capitated managed care contract with a managed care organization with which the beneficiary was actually enrolled, the

[13] Reviews of claims that may be covered by capitation arrangements that do not involve enrollment are discussed in the subsection: "special instructions regarding capitated non-enrollment options."

full amount of the paid claim should be reported as an inaccurate payment. The medical review process needed for this determination is limited to a determination of coverage according to the state's managed care program policies. This does not involve a review of the medical necessity and coverage under the state's medical policies as applied to FFS claims.

Computation of the Payment Accuracy Rate for Capitated Managed Care

The payment accuracy rate for capitated managed care should be estimated in a manner analogous to the fee-for-service accuracy rate described in the previous section. The denominator should include the dollar value of all the capitation payments made in the sample. The numerator should include the dollar value of the portion of the capitation payments made that is accurate. Note that underpayments do not enter the calculation.

In addition, the review may reveal that fee-for-service payments were made in error for some sampled beneficiaries covered under capitated managed care agreements. If so, the dollar value of the fee-for-service payments made in error for services provided during the period for which the beneficiary was covered under a managed care agreement should be reported separately, and not be included directly in the accuracy rate.

The payment accuracy formula can be expressed as follows:

$$AccuracyRate = \frac{AccurateCapitationPayments}{TotalCapitationPayments}$$

Reporting

In reporting the estimated capitation managed care payment accuracy rate, the following information should be provided:

- the payment accuracy rate;
- its standard error and 95 percent confidence interval;
- total sample size;
- dollar distribution and number of errors by the following three reasons:
  - — ineligible beneficiary
  - — incorrect payment amount
  - — fee-for-service payment made in error
- findings and observations resulting from the analysis.

CMS will provide specific guidelines for final reports to ensure that findings are reported consistently across states.

Reporting Options: The respondent may propose alternative ways of reporting results, including:

- alternative error categories;
- standard errors and confidence intervals within strata (if any);
- alternative strata; or
- statistical tests of differences between strata.

However, results must also be reported according to the core requirements of the CMS PAM Model. In addition, if there are any additional costs associated with proposed reporting options, these costs should be broken out separately.

3. Alternative Methodologies

Any innovative alternative methodology proposed must result in a payment accuracy measure that is generalized to either the universe of fee-for-service claims, the universe of managed care payments, or both. States must clearly describe the alternative, its components, and why it is preferred to the CMS PAM Model(s) described above. States should also indicate how the alternative methodology could be applied more generally to other states and how it may be used to generate a national payment accuracy rate. Finally, if there are aspects or features of the alternative methodology that are "optional" in the sense used in the previous sections describing the fee-for-service and capitation CMS PAM Models, the state should indicate those optional features and include them separately in the budget.

Please note that an alternative methodology should be substantially different from the CMS PAM Model. Proposed alternative approaches that are variations on the core requirements of the models described in Sections 1 and 2 should be proposed as options to the models and not submitted separately as an alternative model.

IV. Review Criteria and Process

The state's proposal should contain a technical approach, management plan, and budget. The issues to be addressed in each section and the associated "points" are described below. A total of 140 points may be awarded.

Technical Approach 100 points total

Understanding the Problem 40 of 100 points

The state must demonstrate an understanding of the purpose of payment accuracy measurement in Medicaid. Further, the respondent should provide its understanding of the relevant CMS PAM Model and its strengths and weaknesses. States who have both fee-for-service and managed care should address both aspects. A state who proposes an alternative to the CMS PAM Model(s) should also demonstrate its understanding of the models, their strengths and weaknesses, and why an alternative approach may be desirable. Finally, the state should discuss its understanding of the issues entailed in developing a national payment accuracy measure from state level estimates of accuracy rates.

Approach *60 of 100 points*

The section should begin with a statement that clearly indicates which of the CMS PAM Models the state is proposing to test, and/or if the state is proposing an alternative model.
A state proposing to implement the CMS PAM Model for fee-for-service and/or managed care payment accuracy measures should present its approach to implementing the model(s).

The state should describe how it will develop the sample and how the sample size will be determined. In addition, the state should describe the audit, review and other procedures it will use to validate the claims and indicate how this is consistent with the methods outlined in the core requirements of the CMS PAM Model(s).

States proposing optional features around the core requirements of the CMS PAM Model(s) should describe those features, the rationale for them, the expected benefits, and how the "value added" by these optional features may be determined from the pilot. Finally, the state should indicate how the optional feature proposed is in addition to, not a substitute for, the relevant feature of the CMS PAM Model(s), or explain how the option still preserves the essential elements. (If, for example, the state proposes on-site reviews of medical records documentation rather than letter requests to the provider for documentation, the essential elements of the CMS PAM Model are obviously preserved.)

States proposing an alternative to the core requirements of the CMS PAM Model should clearly define the alternative, describe how it is an improvement over the CMS PAM Model(s), and indicate how it could be generalized across the states. Only alternative methodologies that result in a payment accuracy measure will be considered. Alternatives that validate processes, procedures, or data, yet do not result in a payment accuracy measure, are recognized as potentially being important but are not the subject of this demonstration project.

States for which both fee-for-service and capitated managed care constitute 10 percent or more of their Medicaid program, by dollar value, are encouraged to propose participation in both the fee-for-service and the managed care models. States that propose an alternative methodology are also encouraged to indicate willingness to pilot test the CMS PAM Model should their alternative methodology not be accepted; these states may be given an opportunity to submit a subsequent proposal to pilot test the CMS PAM Model.

In all proposals, potential problem areas or issues should be described, and ways that risks or problems can be mitigated should be indicated.

Management Plan 40 Points

The state should describe how the project will be organized, staffed, and managed. For planning purposes, the state should assume that it will provide quarterly progress reports, and a final report no later than 30 days after the end of the fourth quarter. In addition, the state should plan for two 1.5-day conferences, as described below. The management plan should address the following:

Staffing/Contracting Approach *20 of 40 Points*

The proposed demonstration project must be staffed by persons with the experience and skills necessary to conduct and participate in a Medicaid payment accuracy measurement study. States may also choose to contract with external organizations to conduct parts of the review (e.g., create data extract and sample, conduct medical record review). The state should describe how its staff will be organized and discuss quality control within the demonstration project. (Note: quality control should include a discussion of methods to ensure sample size is correct and drawn appropriately, and that adequate structures are in place to promote consistency and accuracy in medical review.)

Project Timeline and Level of Effort *20 of 40 points*

The state should present a timeline with major milestones, and indicate how the staffing effort is allocated over the timeline. The timeline should be consistent with sampling claims paid in the period October 1 to December 31, 2002, and producing preliminary findings in the period April 1 to June 30, 2003, if possible.

States should plan for two 1.5 day conferences in the Baltimore/Washington D.C. area. The purpose of the first conference will be an interim report on the progress of each participant's pilot study. The second conference is intended to discuss preliminary findings. States shall also submit a final project report thirty days after the end of the project.

Budget

The project budget will not be scored on a point system. Costs will be evaluated relative to the technical merits of the proposal. The CMS goal of the project is to attempt to fund at least fifteen applications. Because the total budget for the project is constrained, costs for individual proposals will also be evaluated based upon achieving this goal.

Using Budget Form SF-424A, provide an estimate of the aggregate expenditures expected to support the project approach and level of effort described above. The budget should clearly delineate the costs associated with the core requirements of the CMS PAM Model(s) proposed. That is, if the state proposes to test both the fee-for-service model and the managed care model, those costs should be separately identified, if possible. Shared costs may be noted. In addition, the costs associated with each optional feature to the core requirements of the model (if any are proposed) should be broken out separately.

Finally, for those states proposing alternative methodologies, if those models have "optional" features to them, the costs associated with the optional elements should be broken out separately in the budget.

V. General Provisions

The states must agree to the following:

Reporting

States receiving awards must agree to cooperate with any evaluation of the product of the work and to provide required information and reports in a format prescribed by CMS. States shall submit quarterly progress reports that are due thirty days after the end of the quarter. States shall also submit a final project report due thirty days after the end of the project; the final report may be submitted in lieu of the fourth quarter report.

Coordination and Meetings

States receiving awards will participate in the demonstration project team. Project Directors or other appointed representatives are expected to participate on scheduled conference calls with the demonstration project team and attend two PAM Project conferences. The PAM Project conferences will be held in the Baltimore/Washington D.C. area and will be used as a forum for team members to present project progress reports, discuss findings, and address administrative concerns.

Civil Rights

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

VI. Applying for This Demonstration Project

Application Format

The application kit can be accessed electronically at www.hcfa.gov/research/grantkit.pdf

Deadline for Submission

Applications are due no later than June 20, 2002, which is 45 days from the date of the solicitation. Applications mailed through the U.S. Postal Services or a commercial delivery service will be considered on time if they are received in the CMS Grants Office or postmarked by the closing date. Submissions by facsimile (fax) transmission will not be accepted. A proposal not postmarked by the closing date will be considered late. Late proposals will not be considered and will be returned without review.

An original proposal should be sent with five copies to:

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

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

VII. Additional Information

For additional information regarding this solicitation, please contact:

Medicaid Payment Accuracy Measurement (PAM) Project
Finance, Systems and Quality Group
Mail Stop S3-13-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attn: Wayne A. Slaughter, Ph.D. (410) 786-0038
Email: wslaughter@cms.hhs.gov

APPENDIX A

STRATA DEFINITIONS FOR SAMPLING SERVICES

Stratum 1: Inpatient Hospital Services

- Inpatient hospital services (other than services for TB or mental diseases)

Stratum 2: Long Term Care Services

- Skilled nursing facility services for individuals 21 or older (other than services for TB or mental diseases)
- Inpatient hospital services for individuals 65 or older in institutions for TB or mental diseases
- Skilled nursing facility for individuals 65 or older in institutions for TB or mental diseases
- Intermediate care facility services for individuals 65 or older in institutions for TB or mental diseases
- Intermediate care facility services other than in an institution for TB or mental diseases
- Inpatient psychiatric services for individuals under age 21
- Services in Christian Science sanatoriums
- Skilled nursing facility for individuals under age 21
- Services furnished during the month admitted to a public institution or an institution for TB or mental diseases

Stratum 3: Independent Practitioners and Clinics

- Outpatient hospital services
- Rural health clinic services
- Physician services
- Medical or other remedial care provided by licensed practitioners
- Clinic services
- EPSDT services
- Diagnostic services
- Screening services
- Preventive services
- Physical therapy, occupational therapy, and other individual services
- Rehabilitation services
- Dental services
- Emergency hospital services
- Services of Christian Science nurses
- Primary care case management

Stratum 4: Prescription Drugs

- Separately billed prescribed drugs

Stratum 5: Home and Community-Based Services

- Home health services
- Private duty nursing services
- Personal care services in a recipient's home

- Hospice
- Home and community-based waiver services
- Targeted case management

Stratum 6: Other Services and Supplies

- Dentures, prosthetic devices, eyeglasses, and hearing aids
- Durable medical equipment
- Other lab and x-ray services
- Transportation
- Other care

Appendix B

Medicaid PAM Project
Medical Review DRAFT Guidelines for
Fee-for-Service Claims Review

(Note: These draft guidelines are provided for information and comment only. The state is not required to adhere to them in its actual medical review. However, the state is requested to comment briefly on the guidelines in its proposal and indicate where its review procedures will be consistent with the guidelines and where it will deviate.)

This document provides general guidelines for medical review for hospital inpatient services, long term care services, and other individual practitioners and clinics. The goals and processes that apply to all areas and the medical review steps are delineated for each type of service. These draft guidelines were developed to provide a basic framework across all states for the medical review process. They should not replace your state guidelines if there are discrepancies, nor is the state required to adhere to these draft guidelines.

Goals of Medicaid PAM Medical Review

1. Identify inappropriate billing in an effort to improve the payment accuracy and decrease the receipt of bills for unnecessary services;

2. Assure that payment is made only for covered items and services as described in state Medicaid guidelines;

3. Assure that services do not exceed the patient's medical needs; and

4. If fraudulent behavior is found, comply with fraud and abuse guidelines for referral to the appropriate area

Recommended Medical Review Steps

1. At the beginning of the medical review process, existing policies and guidelines are researched. The reviewer should be familiar with:

    - Medicaid state policy manual
    - Data analysis statistics for the provider
    - Medical necessity criteria
    - Applicable coding rules
    - Literature searches

2. Claims and the medical records are reviewed and analyzed by a registered nurse.

Nurses review the medical records and determine medical necessity, reasonableness of the paid services under review, and appropriateness of the clinical setting.

Determinations are made based on state Medicaid rules and regulations.

1. During the medical review process, if the provider fails to submit the requested documentation within the prescribed time frame, deny the claim and/or adjust the claim accordingly. If the provider furnishes documentation that is incomplete (insufficient to support medical necessity), adjust the claim in accordance with your state Medicaid payment policy.

2. If payment errors are identified an educational letter is prepared for the facility.

It is recommended the educational letter should contain:

- Specific case examples and errors identified;
- Policy and guideline references and explanation;
- Cite medical necessity, documentation, and coding issues in the letter as indicated;
- The overpayment amount should be included in the letter; and
- Copies of the actual policies and guidelines are enclosed with the letter.

Specific medical review guidelines by type of service:

Hospital Inpatient

In-patient claims and the medical records are reviewed and analyzed by a registered nurse.

Nurses review the medical records and determine medical necessity and reasonableness of the paid services under review.

Determinations are made for:

- Appropriateness of admission;
- Continued stay review;
- Appropriateness of acute setting, and
- Appropriateness and accuracy of ICD-9-CM coding.

Determinations are made based on state Medicaid rules and regulations and medical necessity criteria.

Long Term Care Services

Long term care service claims and the medical records are reviewed and analyzed by a registered nurse.

Nurses review the medical records and determine medical necessity and reasonableness of the paid services under review.

Determinations are made for:

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

Determinations are made based on state Medicaid rules and regulations and other sources submitted such as the minimum data set (MDS).

Other Individual Providers and Clinics

Claims and the medical records are reviewed and analyzed by a registered nurse.

Nurses review the medical records and determine the medical necessity and reasonableness of the paid services under review.

Determinations are made for:

- Medical record documentation substantiation of the services paid.
- Medical necessity of the service is appropriate.
- Appropriateness and accuracy of ICD-9-CM diagnosis coding and CPT procedure coding, and diagnosis supports the procedure code.

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

Request for Medical Record Information

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

It is recommended the sample listing include:

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

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

Inpatient Hospital

- Pre-authorization form if applicable
- Face sheet to include coding for hospital stay
- Complete billing listing of all charges, payments, or adjustments for the hospital stay (Example: account ledger/billing statements)
- Physician's orders and progress notes
- Operative reports
- Pathology reports
- Anesthesia records including pre and post -op
- Admission history and physical
- Nurse's notes
- Medication records
- All laboratory and x-ray reports
- Cardiovascular, procedure/reports (EKG, stress test, echo, etc.)
- All flow sheets (including vital sign records)
- Nursing care plan and/or critical pathways
- Consultation reports
- Discharge summary
- Any emergency room notes related to the admission
- Hospital transfer form (if applicable)
- PT/OT/SLP progress notes (including charts for daily therapy, and documentation of therapy minutes)
- Any additional documentation that demonstrates the medical necessity of the services or procedures performed
- Name and telephone number of the contact person for facility

Long Term Care Services

- Medical eligibility request form
- Signed minimum data set (MDS) – all that apply
- Documentation for look back periods (this may be prior to requested dates of service)
- Physician's orders and progress notes: hospital if applicable and NFS
- History and physical reports
- Nurse's notes for the NFS
- Medication sheets
- All flow sheets, including vital sign records and weight charts
- Nursing care plan
- Consultation reports
- Discharge summary
- Hospital transfer form
- PT/OT/SLP progress notes, including charts for daily therapy, and documentation of therapy minutes
- All treatment plans and therapeutic goals, including objective and subjective findings to support continuing treatment

- Any additional documentation that demonstrates the medical necessity of the service performed
- List of any abbreviations or symbols used and their meanings
- The name and telephone number of the contact person in your facility

Other Individual Providers and Clinics

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