Payment Error Rate Measurement (PERM)

Introduction to PERM

August 2017

Centers for Medicare & Medicaid Services

Agenda

- History and Overview
- Methodology Overview
- Roles and Responsibilities
- Differences Between FY 2015 and RY 2019 Cycles
- RY 2019 Process Details
- Best Practices
- Communication and Collaboration
- Contact Information

History and Overview

Legal Basis for Measuring Medicaid and CHIP Improper Payments

- Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)
  - Identifies Medicaid and CHIP as programs susceptible to improper payments
  - Emphasizes the importance of not only measuring improper payments but recovering and reducing improper payments
  - Replaced the Improper Payments Information Act of 2002 (IPIA) and Improper Payments Elimination and Recovery Act of 2010 (IPERA)
- In FY 2006, CMS implemented the PERM methodology to estimate improper payments in Medicaid FFS
  - Began a 17-state rotation for PERM, where each state is reviewed once every three years
  - Began reporting a national improper payment rate for Medicaid for each federal Fiscal Year (FY)
  - In FY 2007, CMS expanded the methodology to measure the accuracy of Medicaid managed care payments, CHIP FFS and managed care payments, and Medicaid and CHIP eligibility decisions

Continuing Evolution of the PERM Program

- In 2009, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - Required changes to the PERM methodology
  - Postponed CHIP measurement until new rules could be issued
- In 2010, CMS published a new PERM Final Rule in response to CHIPRA
  - State-specific sample sizes
  - Maximum sample sizes
  - MEQC/PERM substitution option
  - More detailed requirements for corrective actions
- In 2010, Congress passed the Affordable Care Act with an effective date of January 1, 2014
  - Required states to make significant changes to Medicaid and CHIP eligibility policies and processes
  - Resulted in a freeze on the PERM eligibility measurement for FY 2014 – FY 2017 with states participating in Medicaid and CHIP eligibility review pilots

Summary of New PERM 2017 Final Rule

- On July 5, 2017, a new PERM Final Rule became effective, making significant changes to both the claims and eligibility measurement
- *Review Period*: PERM is moving back three months from a FY review period to a review period of July 1 through June 30
- *Change in State-specific Sample Size Calculation*: Establishes a national annual sample size which will be distributed across states
- *Use of Claims Sample for Eligibility Measurement*: The PERM claims sample will be used for the eligibility measurement with eligibility reviews being conducted on the individual associated with the sampled claim
- *Introduction of a Federal Eligibility Review Contractor (ERC)*: A federal contractor will conduct PERM eligibility reviews with support from each state
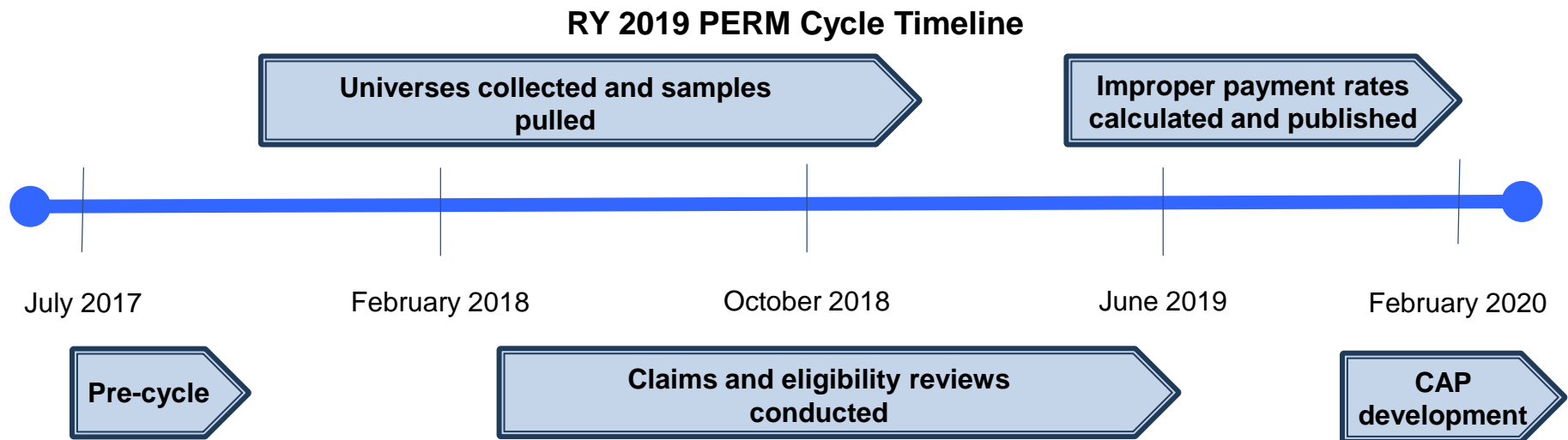
Summary of New PERM 2017 Final Rule

- *System Access Requirements:* States are now required to grant federal contractors access to all systems that authorize payments, eligibility systems, systems that contain beneficiary demographics and provider enrollment information to facilitate reviews
- *Federal Improper Payments*: Improper payments will be cited if the federal share amount is incorrect (even if the total computable amount is correct)
- *Updated Corrective Action Requirements*: There will be more stringent requirements for states that have consecutive PERM eligibility improper payment rates over the 3% national standard established under section 1903(u) of the Social Security Act (the Act). In addition, states will have to provide an evaluation of whether actions they take to reduce eligibility errors will also avoid increases in improper denials

Summary of New PERM 2017 Final Rule

- *Payment Reductions/Disallowances:* Potential payment reductions/ disallowances under section 1903(u) of the Act will be applicable for eligibility reviews conducted during PERM years in cases where a state's eligibility improper payment rate exceeds 3%; CMS will only pursue disallowances if a state does not demonstrate a good faith effort to meet the national standard, which is defined as meeting PERM CAP and MEQC pilot requirements

- *Difference Resolution/Appeals:* Extended the difference resolution time allowance to 25 business days and the appeal time allowance to 15 business days to allow states more time to research errors while still allowing the PERM process to be completed within a reasonable timeframe

PERM Cycle Progression

- Process of sampling and reviewing payments and calculating and reporting improper payment rates takes more than two years
- FFS claims and managed care capitation payments are collected for a full year – July 1, 2017 through June 30, 2018
    - Payments receive a data processing, medical record, and eligibility review
    - Findings are used to calculate improper payment rates
    - States receive findings and develop corrective action plan

RY 2019 PERM Cycle Timeline

Universes collected and samples pulled

Improper payment rates calculated and published

| July 2017 | February 2018 | October 2018 | June 2019 | February 2020 |

Pre-cycle

Claims and eligibility reviews conducted

CAP development

PERM Methodology Overview

Measuring Payment Errors in Medicaid and CHIP

- The goal of PERM is to measure and report an unbiased estimate of the true improper payment rate for Medicaid and CHIP

- Because it is not feasible to verify the accuracy of every Medicaid and CHIP payment, CMS uses a statistically valid methodology that samples a small subset of payments, then extrapolates to the "universe" of payments

- PERM uses a two-stage sampling approach
  - CMS uses a 17-state rotation (each state is reviewed once every three years)
  - From within each state, select a stratified random sample of payments
  - Review the sampled payments for errors
  - Use the findings to estimate a national improper payment rate

- CMS calculates improper payment rates for the 17 states' Medicaid and CHIP programs each cycle and then combines with the improper payment rates for the states of the previous two cycles
  - The national-level rate includes the most recent rates for all states

PERM State Rotation

Cycle	Medicaid and CHIP States Measured by Cycle
Cycle 2 (FY16)	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 3 (FY17)	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington
Cycle 1 (RY19)	**Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming**

PERM Review Types and Sample Sizes

- PERM samples are selected from distinct universes for two programs
  - Programs: Medicaid (Title XIX) and CHIP (Title XXI)
  - Universes: Fee-for-service (FFS) and Managed Care
- Claims selected from the FFS universe are subject up to three different reviews
  - Data processing, medical record, and eligibility
- Payments selected from the managed care are subject up to two different reviews
  - Data processing and eligibility
- PERM will utilize a national sample size that caps the number of samples selected from FFS and managed care as well as the number of eligibility reviews
  - The national sample size will be distributed across states based on the following elements:
    - Expenditures
    - Previous Improper Payment Rate
    - Improper Payment Rate Variation

PERM Cycle Progression

Claims and Payment Measurement
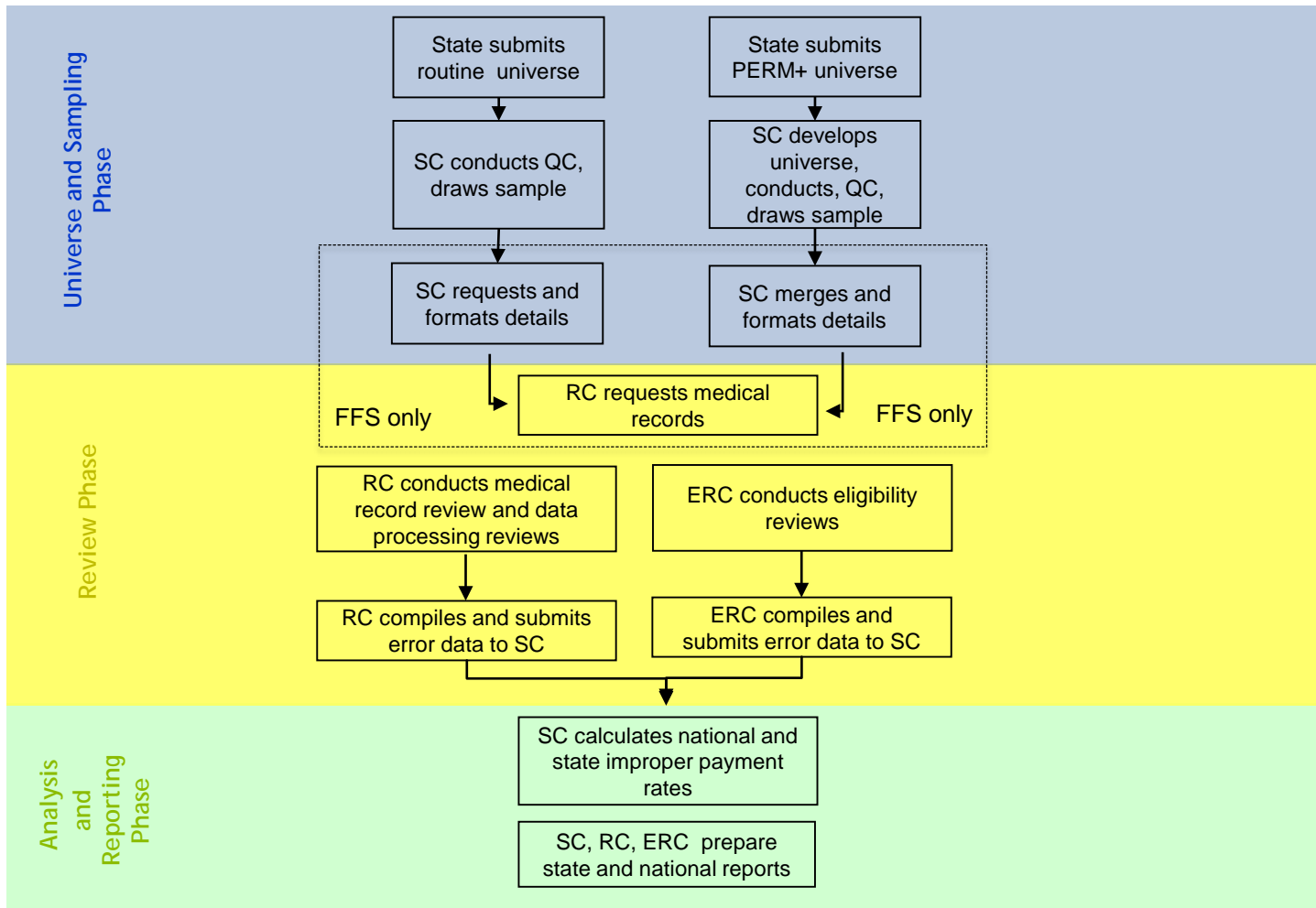
Roles and Responsibilities

CMS PERM Team Responsibilities

- Program Oversight and Support
  - Structure the parameters for measurement through legal and policy decision-making processes
  - Oversee the operation of PERM and PERM contractors to ensure that CMS meets its regulatory requirements
  - Ensure the measurement remains on track and work with states when challenges occur
- Communication and Information Sharing
  - Host monthly cycle calls
  - Provide guidance and technical assistance to states throughout the process
  - Provide educational resources for Medicaid and CHIP providers
- Review, Resolution, and Recovery of Improper Payments
  - Review state-requested appeals of error findings
  - Provide assistance as states develop corrective actions
  - Ensure improper overpayments are recovered

General State Responsibilities

- Overall PERM Support
  - Provide a representative to spearhead PERM
  - Educate state staff and vendors for MMIS or other data sources on the PERM process and data requirements
  - Notify CMS and contractors in advance of any program changes, including new or ended programs, new reimbursement methodologies, or new systems
  - Provide timely and thorough responses to questions on the state-submitted data and review issues to support the PERM timeline
  - Participate in the cycle kick-off meetings, education webinars, and in monthly cycle calls with CMS

State Responsibilities to the SC

- Assign a PERM point of contact
  - Also identify a primary data contact if different than the primary PERM contact
- Universe Quality Control and Data Submission
  - Review claims and payment data submission instructions
  - Provide accurate data documentation (e.g., file layouts, variable field decodes), claims and payment data to the SC
  - Conduct a quality control review of claims and payment data prior to submission of the quarterly universes to ensure completeness of data and compliance with PERM specifications
- Participate in meetings with SC
  - Data intake meeting
  - CMS 64/21 intake meeting
  - Details intake meeting
  - Regularly scheduled and ad hoc calls to respond to data questions

State Responsibilities to the SC

- Convene SMEs, as needed
  - Participate in calls
  - Respond to specific data, program, or policy questions
- Respond timely to questions on universe and details QC
- Support the CMS-64/21 comparison
  - Include financial staff familiar with reports
- Support SC in developing and approving sample unit build (PERM+)
- Support SC in developing strata mapping for Fixed, Medicare Crossovers, and Aggregate payments

State Responsibilities to the RC

- Support the Claims Review Process
  - Educate providers on the PERM process and assist with medical record collection
  - Assist the RC with accessing state policies for review
  - Assist the RC with on-site and/or remote data processing reviews
  - Work with RC to grant system access timely to prevent review delays
- Review, Resolve, and Address Improper Payment Findings
  - Track errors and request Difference Resolutions (DRs)/appeals for differences and re-price partial errors
  - Develop and implement corrective actions to reduce improper payments
  - Return Federal Financial Participation (FFP) of FFS and managed care overpayments

State Responsibilities to the ERC

- Assign a state eligibility point of contact
- Participate in meetings with the ERC and CMS:
  - Eligibility-specific Welcome Webinar
  - Intake Meeting
  - System(s) Access meeting(s)
  - Regularly scheduled calls (e.g. Cycle Calls, All-State Calls, etc.)
  - Check-in and other meetings (throughout the case review process)
- Provide access to eligibility and documentation management systems
- Provide state eligibility policies, as requested
- Provide guidance related to systems, policy, and other pertinent topics
- Assist in obtaining required information from other state agencies
- Review the ERC's case review findings
- Submit request for difference resolution and appeals, if needed

Statistical Contractor Responsibilities

- Collect and Review State FFS and Managed Care Universes
  - Conduct Intake Meetings with each state
  - Collect paid, zero dollar paid, and denied FFS and managed care universe data from states on a quarterly basis
  - Verify data documentation against data submission
  - Perform quality control review on state submissions to ensure universes are accurate, compliant, and complete
  - Develop and implement sampling unit build (for PERM+)
  - Determine correct sampling units (H/F/L) for each type of claim/service
  - Request clarification or additional submissions as necessary
  - Conduct CMS-64 reconciliation to ensure all required data are included in review
- Select Samples and Format State Claims
  - Select quarterly random samples from the universes on a quarterly basis
  - Request sample details from the states for sampled FFS claims for routine PERM states and build details for PERM+ states
  - Format and verify all mandatory fields needed for RC and ERC review
  - Deliver samples and details to the RC and ERC

Statistical Contractor Responsibilities

- Improper Payment Rate Calculation and Reporting
  - Calculate the component (FFS and managed care), state, and national improper payment rates for Medicaid and CHIP
  - Conduct analysis for corrective actions
  - Assist in preparing final reports

Review Contractor Responsibilities

- Prepare for Data Processing and Medical Record Reviews
  - Facilitate state implementation by confirming readiness prior to on-site or remote reviews, providing IT support, and overall reducing state burden
  - Research, collect, and request Medicaid and CHIP state policies, including relevant state regulations, program information, fee schedules, systems, and billing manuals
  - Conduct RC Educational Webinars for all states on data processing, medical record requests, and medical review processes
- Conduct Data Processing and Medical Record Reviews
  - Request medical records from providers
  - Conduct data processing (DP) reviews on all sampled payments
  - Conduct medical/coding reviews (MR) on relevant sampled FFS payments
  - Maintain the State Medicaid Error Rate Finding (SMERF) system, conduct SMERF training webinars, and provide state portals to track activities and findings

Review Contractor Responsibilities

- Finalize Review Findings and Support Improper Payment Rate Calculation and Reporting Process
    - Report final review findings to states through Sampling Unit Disposition (SUD) reports on the 15th and 30th of each month
    - Review and respond to requests for difference resolution (DR)
    - Process appeal requests for CMS review
    - Notify states of final overpayment errors for recovery purposes at the end of the cycle after data processing and medical review are completed
    - Compile and submit final findings to the SC
    - Assist in preparing final reports

Eligibility Review Contractor Responsibilities

- Research state and federal Medicaid and CHIP policies and procedures
- Request from the state any policies that are not publicly available
- Populate and provide the Policy Survey to the state
- Provide the Systems Access Questionnaire to the state
- Conduct an Intake Meeting with the state
- Coordinate with the states to obtain access to eligibility systems
- Finalize the Eligibility Case Review Planning Document based on state's specific systems, processes and policies, and submit to state to review for accuracy

Eligibility Review Contractor Responsibilities

- Request copies of hard-copy case files, when necessary
- Gather information form the eligibility system and electronic imaging systems, including electronic verifications
- Request additional documentation from the state, if needed
- Review eligibility case actions in accordance with the federal and state policies
- Report final review findings to the states through Sampling Unit Disposition (SUD) reports via SMERF on the 15th and 30th of each month
- Provide case review information to the states for cases containing technical deficiencies and payment errors
- Review and respond to requests for difference resolution (DR)
- Process appeal requests for CMS review

Eligibility Review Contractor Responsibilities

- Host regular check-in meetings with the states
- Participate in a debrief meeting with the state and CMS following the PERM eligibility cycle
- Support the state in identifying and developing strategies to resolve issues as documented in the state's CAP
- Consult with RC on overlapping matters including; but not limited to, scheduling for potential onsite reviews and systems access training

Differences Between FY 2015 and RY 2019 Cycles

SC Processes:
Difference between cycles (FY15 & RY19)

FY 2015 Cycle	RY 2019 Cycle
FFS Stratification by four service types and "other" category	Back to previously used payment strata (with the addition of a data processing only stratum, including fixed/aggregate/Medicare Crossover payment and denied) There will be 5 payment strata instead of 10
Data intake process	General data intake questions and answers gathered prior to call based on prior cycle responses First call will focus on technical intake There will be a separate CMS-64/21 financial intake
Recipient ID and recipient name required for fixed payments	Recipient ID, gender, date of birth, county/service area, eligibility category, date of death (if applicable), and name are required for ALL claims

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SC Processes:
Difference between cycles (FY15 & RY19)

FY 2015 Cycle	RY 2019 Cycle
Performing provider information = attending/servicing provider information in details	Performing provider fields for institutional claims should contain attending provider information All other claims will still maintain servicing provider in performing provider fields
Routine PERM states send in payment level information with their claims	Routine PERM states are sent a payment level verification email that examines the payment levels for each type of service and asks questions about payments

SC Processes: New to Cycle 1 States

- New fields required in either the PERM+ universe submission or in the routine PERM details submission
  - ICD Indicator: Indicates which ICD coding set is applicable to the claim line
  - Billed information
    - Units Billed: Used to indicate Units of Service billed if that number is different from the value in the Units Paid field
    - Billed procedure/diagnosis codes: Any procedure or diagnosis codes submitted on the billed claim which are different from the final codes on the claim when paid
    - Billed amount: The dollar amount listed on the claim when submitted for payment. This may differ from the actual paid amount.

RC Processes:
Difference between cycles (FY15 & RY19)

FY 2015 Cycle	RY 2019 Cycle
ICD-9 code sets used to report medical diagnoses and inpatient procedures	ICD-10 code sets used to report medical diagnosis and inpatient procedures for dates of service on and after October 1, 2015
Review platform • Primarily onsite with limited remote system access • Eligibility reports	Review platform • Primarily remote system access with limited onsite • Increased use of data reports and/or extracts
Only one DP error and one MR error was identified on a sampled claim	All DP errors and MR errors identified will be cited on a sampled claim
Review process • Average 2-4 weeks • Increased sample sizes	Review process: • Reviews average 4-8 weeks • Increased review requirements • Plan of Care is no longer reviewed as part of the DP review

RC Processes:
Difference between cycles (FY15 & RY19)

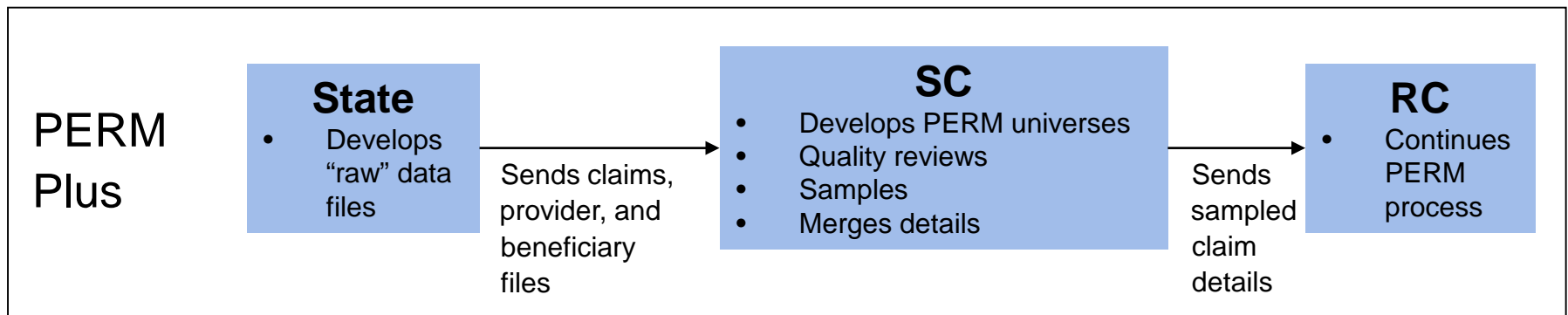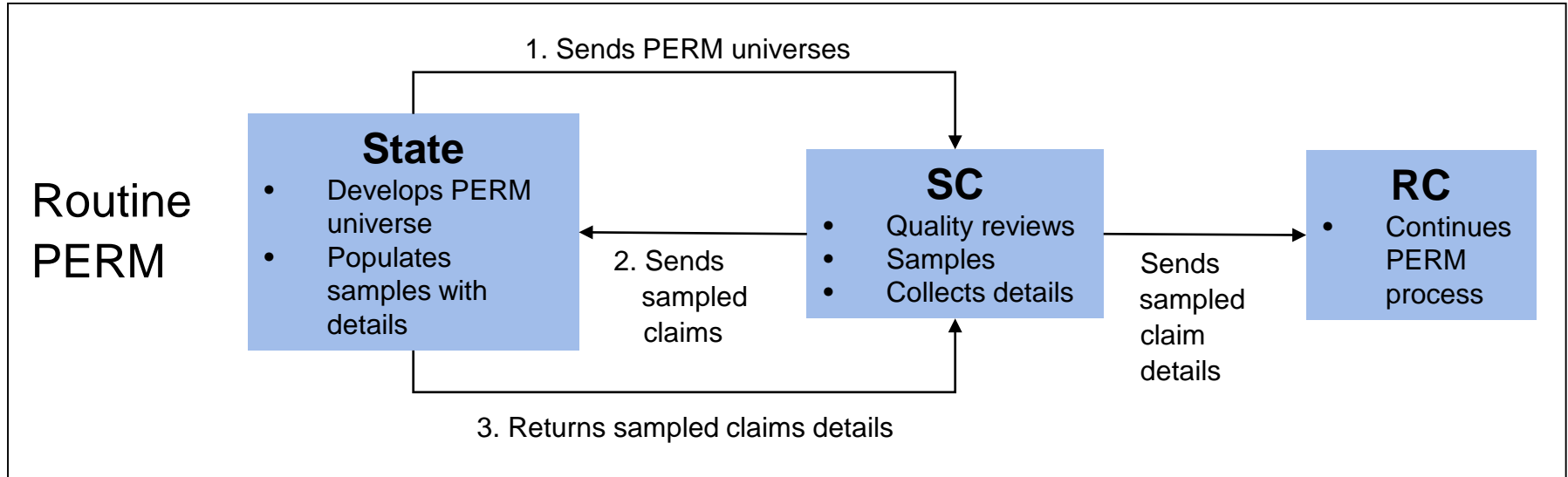| FY 2015 Cycle	RY 2019 Cycle
SMERF 2.0	Enhanced SMERF 3.0 application: • Increased functionality • Ability to create individualized reports • Additional notification alerts (e.g., receipt of documentation and additions to pending list) • Discontinued monthly FEFR reports • Modified screen and reporting display to support multiple errors on a claim • Added tab for eligibility findings
Individual state orientation calls	Enhanced communication with states: • Introductory Webinar (questionnaire review) • Pre-entry conference (check-list discussion) • Group educational webinars • Individual state check-in calls, as needed

RC Processes: New to Cycle 1 States

- Modified MR and DP error codes and qualifiers
  - Expanded qualifiers and sub-qualifiers for specificity
- States are required to grant federal contractors access to all systems that authorize payments, eligibility systems, systems that contain beneficiary demographics and provider enrollment information to facilitate reviews
- Increased DP review requirements
  - Verify the state compliance with FCBC requirements for high risk providers
  - Verify state compliance with provider revalidation requirements
  - Enrollment of managed care participating providers
- Difference Resolution (DR)/Appeal
  - Difference Resolution (DR) Requests are due no later than 25 business days after errors are posted on the Sampling Unit Disposition (SUD) reports (posted on the 15th and 30th of each month)
  - Appeal Requests to CMS for all DR error decisions upheld by the RC are due no later than 15 business days after the DR decision is emailed and posted to SMERF
  - Appeal requests with additional documentation submitted will be re-reviewed at DR level
  - Appeal requests with no additional documentation submitted will be reviewed at appeal level

ERC Processes: New to Cycle 1 States

- Eligibility Case Reviews
  - The eligibility sample will be selected from the same sampling universe as the claims sample
  - A national contractor, the Eligibility Review Contractor, will conduct eligibility reviews
  - States are required to provide access to the required eligibility systems to the ERC
- Error Codes and Qualifiers
  - The ERC will use the updated error codes and qualifiers for the review findings
- Review Results
  - Eligibility review findings will be available through SMERF
  - States have the opportunity to review errors and technical deficiencies and request a difference resolution through SMERF with the ERC or appeal to CMS if an agreement cannot be reached during the difference resolution process

Process Details

Statistical Contractor: Universe Collection and Sampling

Routine PERM

1. Sends PERM universes

State
- Develops PERM universe
- Populates samples with details

2. Sends sampled claims

SC
- Quality reviews
- Samples
- Collects details

Sends sampled claim details

RC
- Continues PERM process

3. Returns sampled claims details

PERM Plus

State
- Develops "raw" data files

Sends claims, provider, and beneficiary files

SC
- Develops PERM universes
- Quality reviews
- Samples
- Merges details

Sends sampled claim details

RC
- Continues PERM process

Statistical Contractor: Universe Collection

- PERM independently samples payments from four universes or program areas
  - Medicaid FFS
  - CHIP FFS
  - Medicaid managed care
  - CHIP managed care
- The PERM universe contains most Medicaid and CHIP service payments that are fully adjudicated by the state that are matched by federal funds each quarter
  - Includes individual claims, capitation payments, and payments processed outside of MMIS or made in aggregate for multiple services
  - Includes expansion program data
  - Excludes claim adjustments, administrative payments, state-only expenditures, and certain payments as defined in regulation
- Certain fields (e.g. date paid, amount paid) have PERM-specific definitions that are important for consistency

Statistical Contractor: Sampling

- Both FFS and managed care universes are stratified prior to sampling
- RY 2019 will use the following stratification approach:
  - FFS is stratified into 5 dollar-weighted strata (including $0 paid) with one additional strata for claims that are only capable of receiving data processing review (e.g., denied claims, fixed payments, Medicare premiums, and Medicare crossovers)
  - Managed care is stratified into 5 dollar-weighted strata
- The Statistical Contractor will calculate state-specific sample sizes for each claim component in each state (final sample sizes sent to states)

Statistical Contractor: Improper Payment Rate Calculation

- For each state, improper payment rates are estimated separately for Medicaid and CHIP
  - Improper payment rates are estimated using a sample of claims
- FFS, managed care, and eligibility rates are calculated separately (where applicable)
- The FFS and managed care rates are combined to make the claims rate using the state expenditures in each program as weights
- The claims rate is then combined with the eligibility rate

Review Contractor: Collection of State Policies

- Send initial email to states prior to implementation
  - Explain policy collection process and timeframes
  - Establish policy contacts with each state
- Download policies from state websites (as much as possible)
- Policies accessible in SMERF system
- Complete policy questionnaires and Master Policy Lists (MPLs) and submit to states for review
- Check for policy updates throughout the cycle
- Written approval of MPLs needed from states before medical review can begin

Review Contractor: Data Processing Reviews

- DP reviews are conducted on each sampled FFS claim, fixed payment, and managed care payment
- The RC validates that the claim was processed correctly based on information found in the state's claims processing system and provider files
- Reviews can take place on-site at the state or remotely
- Data Processing orientation is scheduled with each state prior to reviews
  - Review state system(s) questionnaires completed by states
  - Review any special programs (waivers, etc.)
  - Demonstrate any new systems
  - Determine and gather desk aids, manuals, and website links needed for training DP reviewers
  - Discuss remote vs. on-site reviews and establish tentative dates to begin reviews
- States track pending DP reviews through SMERF and receive automated notices for overdue pending information needed to complete reviews

Review Contractor: Data Processing Reviews – Beneficiary Review

- Reviewer reviews and verifies the following:
    - Beneficiary ID
    - Date of Death
    - Date of Birth/Age
    - County of Residence
    - Gender
    - Citizenship Status
    - Living Arrangements
    - City/Zip code (if needed to determine managed care status)
    - Aid category/program eligibility and effective dates, (relative to sampled dates of service) from direct access to eligibility source system
    - Managed care/health plan enrollment
    - Patient Liability/level of care, if applicable
    - Medicare and/or other insurance coverage (TPL)

Review Contractor: Data Processing Reviews – Verification of Provider Enrollment

- Only reviewed when provider is required to be enrolled
- Reviewer reviews and verifies the following:
  - Provider Name
  - Provider NPI Number
  - Registration/enrollment
  - Provider License (if required)
  - CLIA Certification (if required)
  - Type/specialty
  - Provider and Service Location
  - Provider Sanctions/Suspension Periods
  - OIG LEIE verification check conducted independently
  - Compliance with provider enrollment/risk-based screening requirements under ACA
  - Provider revalidation – claims paid after 3/24/16 (unless provider was notified prior to 3/24/16; then must be screened by 9/24/16)

Review Contractor: Data Processing Reviews – Verification of Accurate Payment

- Reviewers determine the following:
    - The payment was for a covered service
    - The payment was accurately calculated
    - To ensure these two requirements are met and complete, reviewers will:
    - Determine if system uses ICD10 codes for claims with Date of Service on or after 10/1/2015
    - Verify timely filing requirements
    - Review reference screens with service parameters*
    - Review reference screens with rates†
    - Verify service coverage determination
    - Review prior authorization requirements
    - Verify prior authorizations issued‡

* NDC, procedure codes, revenue code, etc.

† DRG, NDC, per diem, provider contract, procedure codes, revenue codes, RVU, etc.

‡ Service codes, effective dates, units, rates, etc.

Review Contractor: Data Processing Reviews – Verification of Accurate Payment

- Reviewers will re-price each sampled payment manually to determine if the payment was made in accordance with published state policies and rates in effect for the dates of service under review

> **Does the state make retroactive rate adjustments?**

- Reviewers will need access to the rates that were in effect for the dates of service for claims under review

- Reviewers will also need:
  - Information about how the state calculates each type of payment
  - Ability to complete a duplicate check to ensure the same service was not paid more than once or to multiple providers for the same dates of service
  - Hard-copy paper claims or the ability to view the scanned image of the paper claim to verify accurate transference of information to the payment system
  - To view any adjustments made within 60 days of the original sampled claim payment date
  - Access to value code tables or a data dictionary of codes used in the system if not contained in system help

Review Contractor: Data Processing Reviews - Managed Care Capitation Payment

- Reviewers will review all beneficiary information listed under FFS review
- Reviewers will also need access to:
    - Capitation rates
    - Capitation payment history screens
    - Geographical service areas (counties, zip code)
    - Managed care contract for sampled claims
    - Population carve-outs
    - Service carve-outs
    - Rate cells

Review Contractor: Medical Record Requests

- RC educational webinars are held with all states to review Medical Record Request processes before starting calls to providers
- The RC will use the provider information received in the details files, submitted by the states, in order to contact providers and send request letters
- Provider information is verified during the initial live call
  - If the provider cannot be reached, State support is needed to help identify the correct contact information
- Initial letter request packets sent to providers include:
  - CMS letter (with authority to request records)
  - PERM fax cover sheet with specific list of requested documentation (unique to each claim category)
  - Claim summary data provided for specific claim sampled
  - Instructions with different options for record submission

Review Contractor: Medical Record Requests

- Providers have 75 calendar days to send in medical records
  - The RC will follow-up with reminder calls and reminder letters at 30 days, 45 days, and 60 days, if the record has not been received
  - A 75-day non-response letter (MR1 error) is sent to providers and made available to states through their SFTP accounts
- Incomplete documentation: Providers have 14 calendar days to send in documentation in response to additional documentation requests
  - Specific details are provided verbally by medical reviewers and in writing for missing documentation – reminder calls and letters sent at 7 days
  - A 15-day non-response letter (MR2 error) is sent to providers and made available to states through their SFTP accounts
- Late documentation can be accepted until the cycle cut-off date

Review Contractor: Medical Reviews

- Medical Review orientations are held for all cycle states, as part of the RC Educational Webinars, to include:
  - Medical review process
  - Difference Resolution/Appeals process
  - Medical review/policy questionnaire
- Conducted only on sampled FFS claims
- Utilizes claims data submitted by states, records submitted by providers, and collected state policies
- Validates whether the claim was paid correctly by assessing the following:
  - Adherence to states' guidelines and policies related to the service type
  - Completeness of medical record documentation to substantiate the claim
  - Medical necessity of the service provided
  - Validation that the service was provided as ordered and billed
  - Claim was correctly coded

Review Contractor: State Medicaid Error Rate Finding (SMERF) System

- Tracks all sampled unit workload, receipt of medical records, reviews pending information, reviews completed, and final results

- Provides real-time information on status of record requests and receipts; progress of reviews for both Data Processing and Medical reviews

- State's access includes ability to create and/or download reports, file for Difference Resolution and CMS appeals, and access Final Error For Recovery Reports for recovery of overpayment errors

- Training and access to the SMERF system is provided for before records are requested or reviews are started

- Access is limited to states, contractors, and CMS through password protection

Eligibility Review Contractor: Collection of State Policies

- Download policies from public websites (as much as possible)
- Request from the state any policies that are not publicly available
- Use information gathered to populate the Policy Survey
- Submit the Policy Survey to states for review
- Check for policy updates throughout the cycle

Eligibility Review Contractor: Eligibility Case Review Planning Document

- The purpose is to have a shared document among the state, the ERC, and CMS that outlines necessary components of the cycle activities and provides details necessary for conducting eligibility case reviews

- The Planning Document includes information such as:
  - State, CMS and ERC points of contact
  - Sample information
  - Timeline of review
  - State Medicaid/CHIP background information
  - Case review process and findings via SMERF
  - Error codes and qualifiers
  - Review tools
  - State systems
  - Documentation request process
  - Difference resolution and appeals process
  - Federal Medical Assistance Percentages (FMAP)
  - Any additional state-specific information

Eligibility Review Contractor: Eligibility Reviews

- Determine case action(s) and action date(s) for review. The review will include the most recent determination or redetermination and any change in circumstances that required an action if both occurred prior to the DOS of the sample claim

- Access and review information used by the state to process the case in the form of system screen prints and case documents that support the eligibility determination

- Review eligibility elements against federal and state policies and determine if the case is correct or if a payment error or technical deficiency should be cited

Federal Medical Assistance Percentage (FMAP)

- The FMAP rate will be collected by the ERC to identify federal dollars assigned to a claim for each type of PERM review based the following:
  - Services received
  - Special eligibility populations
  - Category of eligibility

Eligibility Review Contractor: Eligibility Review Elements

- Age
- Gender
- Relationship
- Citizenship
- Immigration Status
- State Residency
- Social Security Number
- Pregnancy

- Household Size
- Tax Filer Status
- Income
- Resources/Assets (Non-MAGI)
- Blindness, Disability, Medical Eligibility
- Notices

Eligibility Review Contractor: System Access

- The PERM Final Rule of 2017 requires states to grant federal contractors access to all systems that authorize payments, eligibility systems, systems that contain beneficiary demographics and provider enrollment information to facilitate reviews

- States may provide either remote or onsite system access
    - States have claimed remote access is less burdensome for them

- The ERC will collect case documentation by directly accessing the states' systems
    - States may have to provide additional documentation securely, if all necessary documentation are not available via system access (e.g. paper files)

- Following the eligibility Intake Meeting, the ERC will coordinate with the states to obtain system access. The ERC will
    - Gather information about each system from the states
    - Execute any data use agreement (DUA) necessary to access the state systems
    - Take any required training

Eligibility Review Contractor: Additional Record Requests

- Upon the ERC's initial review of the information collected, the ERC may identify cases with missing information or incorrect timeframes in which the ERC will request the states to provide additional documentation
  - The ERC will also answer any questions about the additional documentation request during the regularly scheduled check-in calls
- States will submit the requested documentation to the ERC via Secure File Transfer Protocol (SFTP)
- This process will be described in the Eligibility Case Review Planning Document the ERC will share with the states following the Intake Meeting

Eligibility Review Contractor: State Medicaid Error Rate Finding (SMERF) System

- SMERF is the single system for the states to view DP, MR, and eligibility findings
- States will see a new eligibility module in SMERF
  - Track completed eligibility reviews and final findings
  - Eligibility review findings through the Sampling Unit Disposition (SUD) reports on the 15th and 30th of each month
  - States request Difference Resolution and Appeals via SMERF for eligibility related errors
- The following process will be performed outside of SMERF
  - The states will provide the additional documentation to the ERC via the ERC's SFTP

Best Practices

Best Practices for States: Working with the Statistical Contractor

- Assign a dedicated contact person for all communications
- Include all relevant staff in the intake meetings
  - For general intake meetings, it is important that all departments that will be pulling data or responding to questions about PERM data be in attendance
  - If vendors will be pulling and/or submitting PERM data, they should be included in intake meetings and calls with the SC
  - All relevant financial staff should be included in the CMS 64/21 intake meetings
- Check FTP compatibility before submitting the Q1 data
  - This includes encrypting, password-protecting, and uploading file
- Submit test data to ensure that the submission can be read and reviewed by the Statistical Contractor
  - States should perform quality checks to make sure data fields are uniformly populated with valid values
  - States should compare data documentation submitted with data – file layouts and variable decodes – are all up to date and accurate for timeframe of data supplied
  - Note additional variables that are necessary to be included in the data submission to assist state staff or SC in identifying correct claim

Best Practices for States: Working with the Statistical Contractor

- Keep a list of all data sources and ensure that data from all sources are included in the state's transmission each quarter

- Include subject matter experts as part of the PERM team early in the cycle to gain clear understanding of data submission instructions and PERM requirements

- Refer to information from the previous cycle, as appropriate, to resolve issues and answer questions

- Participate in regular meetings with the SC to resolve data issues if there are significant complications or delays

- Perform a round of CMS-64/21 reconciliation early in the cycle to ensure that corrections in data submission can be made for the remaining quarters

- For PERM+ states, work with the Statistical Contractor to identify the most efficient method of submitting data, which may include submitting some data through a routine PERM method

- For PERM+ states, verify that beneficiary and provider information given to SC in separate files are able to be correctly merged onto the claims file

Best Practices for States: Working with the Review Contractor

- Allocate resources to PERM throughout the cycle at each phase of the project (policy collection, provider record requests, data processing review, and medical review)

- Correct any issues identified from the last PERM measurement cycle

- Collaborate with the Review Contractor to explain the state's programs, data, and policies

- If the state routinely purges claims
  - Have the purge process held until after PERM reviews
  - If already purged prior to sampling, identify all purged sampled claims and have the full claim re-populated in the system prior to the start of DP reviews

Best Practices for States:
Working with the Review Contractor

- Keep provider licensing information updated in the MMIS system
- Update provider contacts in MMIS for claims sampled for PERM before the state submits quarterly detail data to the Statistical Contractor
- Send outreach letters to each sampled provider about the PERM program and MRR processes before MRRs begin
- Provide the RC with updated provider contact information, as needed
- Identify a contact person for corporate medical organizations, school systems, and state fiscal agencies

Best Practices for States:
Working with the Review Contractor

- Develop integrity teams to assist with locating and contacting providers, when needed

- Track all medical record requests in SMERF to assure providers' timely responses

- Contact providers on all non-response error letters (MR1s for no documentation and MR2s for document(s) absent from record) to submit requested documentation

- Review all errors cited and determine if a DR request should be filed within 25 business days of the SUD report

- All errors that should be partial errors must have a DR request to re-price the claim and submit written evidence

- Review all DR decisions where errors were upheld and determine if an appeal should be filed within 15 business days of the SUD report

Best Practices for States: Working with the Eligibility Review Contractor

- Engage a cross-functional state PERM eligibility team that includes: policy, systems, claims, program integrity, and operations
- Establish system access for the ERC
  - Identify all systems required by the ERC
  - Provide all required system access forms as soon as possible
  - Designate an individual to work with ERC on system access
- Support the collection of Medicaid and CHIP policies
  - Identify policies not publicly available and submit to the ERC
  - Review policy survey promptly and provide feedback
  - Notify the ERC of any changes
- Respond to request to review the eligibility category/mapping/FMAP crosswalk
- Review and respond to questions involving eligibility case review process

Communication and Collaboration

Communication and Collaboration

- **RY 2019 PERM Cycle 1 Calls**
  - The cycle calls will occur on the Fourth Wednesday of each month from 1:00 – 2:00 pm Eastern Time
  - First cycle call will be held on August 30, 2017

- **PERM Technical Advisory Group (TAG)**
  - Quarterly TAG calls as a forum to discuss PERM policy issues and recommendations to improve the program
  - Regional TAG reps

- **CMS PERM Website**
  - www.cms.gov/PERM

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