CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Payment Error Rate Measurement (PERM)

Introduction to PERM

September 2020

Centers for Medicare & Medicaid Services

Agenda

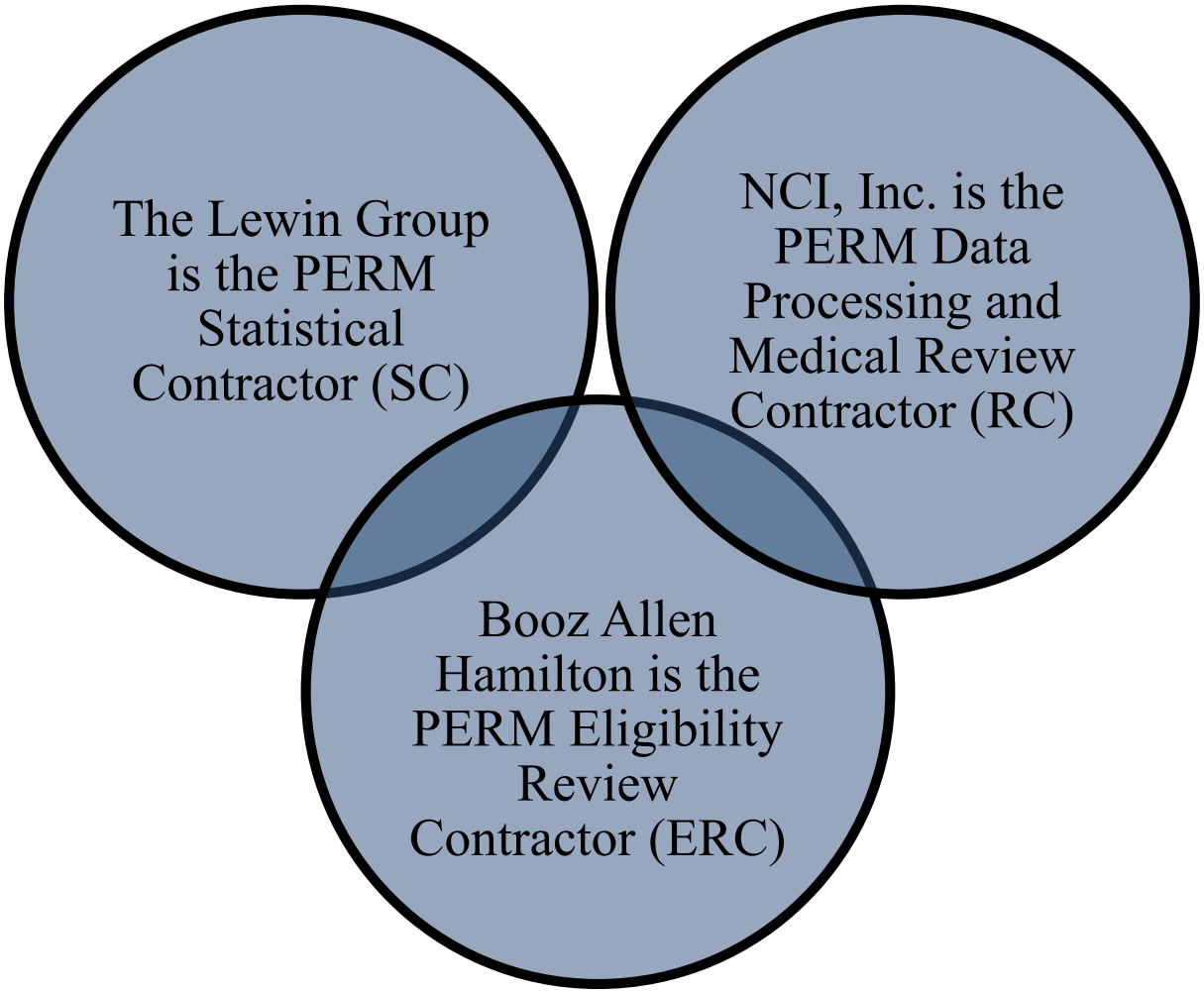
- PERM Overview
- Methodology Overview
- Roles and Responsibilities
- Differences Between RY 2019 and RY 2022 Cycles
- RY 2022 Process Details
- Best Practices
- Communication and Collaboration
- Contact Information
- Appendix: History of PERM

PERM Overview

Legal Basis for Measuring Medicaid and CHIP Improper Payments

- The PERM program measures and reports a national improper payment rate for Medicaid and the Children's Health Insurance Program (CHIP) to comply with the requirements of the Payment Integrity Information Act (PIIA) of 2019
- On July 5, 2017, a new PERM Final Rule became effective, making significant changes to both the claims and eligibility measurement
  - A summary of PERM 2017 Final Rule as well as the history of PERM can be found in the Appendix

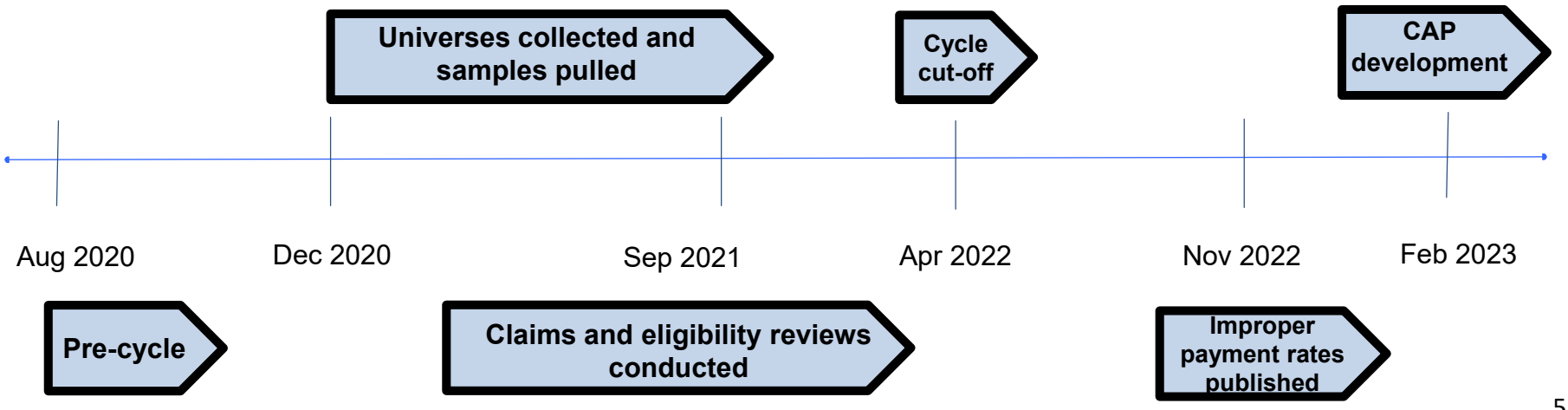
PERM Contractors



PERM Cycle Progression

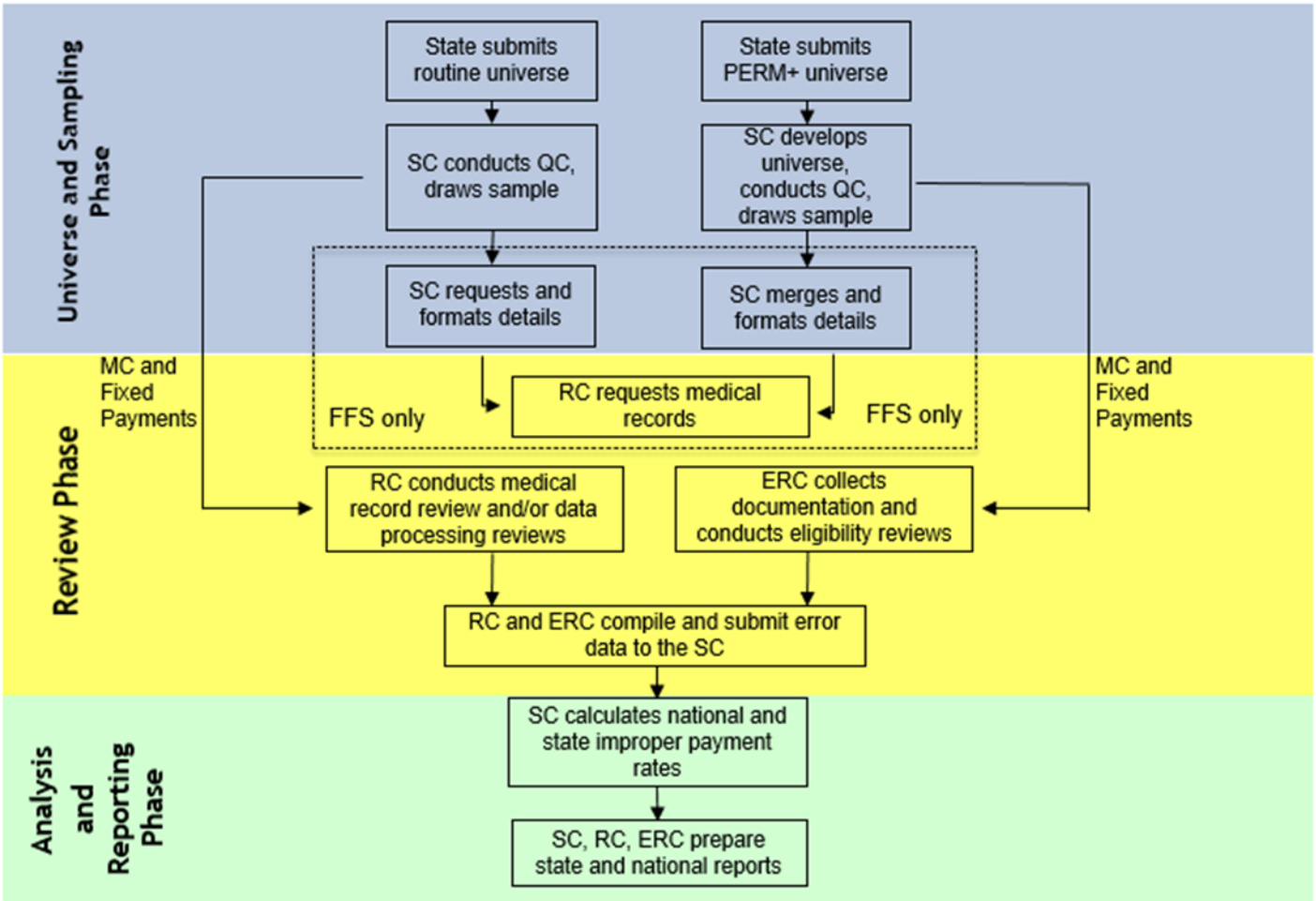
- Process of sampling, reviewing payments, calculating and reporting improper payment rates takes more than two years
- FFS claims and managed care capitation payments are collected for a full year – July 1, 2020 through June 30, 2021
  - Payments receive a data processing, medical, and/or eligibility review
  - Findings are used to calculate improper payment rates
  - States receive findings and develop corrective action plan

RY 2022 PERM Cycle Timeline



Claims and Payment Measurement

Routine PERM vs. PERM+



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 per cycle (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 program and CHIP within each cycle and then combines with the improper payment rates for the states of the previous two cycles to calculate the national-level improper payment rate
  - The national-level rate includes the most recent rates for all states

PERM State Rotation

Cycle	Medicaid and CHIP States Measured by Cycle
Cycle 1 (RY22)	**Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming**
Cycle 2 (RY20)	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 (RY21)	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

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 to as many as three different reviews
  - Data processing, medical, and eligibility
- Payments selected from the managed care universe are subject to as many as two different reviews
  - Data processing and eligibility
- PERM will utilize a cycle sample size across 17 states each year that caps the number of samples selected from FFS and managed care as well as the number of eligibility reviews
- The cycle sample size will be distributed across states based on the latest state expenditures
- All review results are reported via State Medicaid Error Rate Finding (SMERF), a web based application hosted by the RC

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
  - Provide direct communication and support by assigning each state a CMS liaison
- Review, Resolution, and Recovery of Improper Payments
  - Review state-requested appeals of error findings
  - Provide states with summary reports to develop corrective actions, provide assistance as states develop corrective actions, and provide states with final recovery reports

General State Responsibilities

- Overall PERM Support
  - Provide a representative to spearhead PERM who will coordinate state staff and ensure essential state staff attend relevant meetings, as well as provide contractors with necessary data and information and keep them apprised of any state issues
  - 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 meeting, education webinars, all-state calls, and monthly cycle calls with CMS
  - Notify contractors of any Data Use Agreements, Business Associate Agreements, or Non-Disclosure Agreements requiring completion
  - Assist contractors in obtaining systems access

SC 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 (Header/Fixed/Line) for each type of claim/service
  - Request clarification or additional submissions as necessary
  - Conduct CMS 64/21 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

SC Responsibilities (cont'd)

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

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 submission instruction meeting
  - 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 (cont'd)

- Convene Subject Matter Experts (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 the SC in developing and approving sample unit build (PERM+)
- Support the SC in developing strata mapping for Fixed, Medicare Crossover, and Aggregate payments

RC Responsibilities

- Prepare for Data Processing and Medical Reviews
  - Facilitate state implementation by confirming readiness prior to 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 orientations for all states on data processing review, medical record requests, and medical review processes
- Conduct Data Processing and Medical Reviews
  - Request medical records from providers
  - Conduct data processing reviews on all sampled payments and an exit conference at the end of each weekly visit
  - Conduct medical/coding reviews on relevant sampled FFS payments
  - Maintain the SMERF system, conduct SMERF training webinars, and provide state portals to track activities and findings

RC Responsibilities (cont'd)

- 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 or as directed by CMS
  - 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, eligibility, and medical review are completed
  - Compile and submit final findings to the SC
  - Assist in preparing final reports

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
  - Work with the RC to grant system access timely to prevent review delays
  - Assist the RC with data processing reviews within the prescribed timeframes
  - Monitor PERM IDs on the pending documentation list
  - Respond timely to RC requests for documentation
- Review, Resolve, and Address Improper Payment Findings
  - Track errors, request DRs/appeals for disputes of findings, and re-price partial errors

State Responsibilities to the RC (cont'd)

- Participate in meetings with the RC and CMS
  - Data processing orientation
  - Medical review/medical record request orientation
  - State check-in meetings
  - SMERF system training

ERC Responsibilities

- Prepare for Eligibility Case Reviews
  - 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
  - Populate and 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
  - Provide the Eligibility Case Review Planning Document based on state's specific systems, processes, and policies and submit to state to review for accuracy
  - Associate state eligibility groups with the appropriate federal group and Federal Medical Assistance Percentage (FMAP) rate

ERC Responsibilities (cont'd)

- Conduct Eligibility Case Reviews
  - Request copies of hard-copy case files, when necessary
  - Gather information from the eligibility and document management systems, including electronic verifications
  - Request additional documentation from the state, as needed
  - Review eligibility case actions in accordance with the federal and state policies
  - Host regular check-in meetings with the states
  - Coordinate with the RC when scheduling reviews, check-in meeting, and systems access training to ease state burden when possible
  - Support the RC by providing available eligibility information necessary to conduct data processing reviews
- Report Eligibility Case Review Findings
  - Report final review findings to the states through SUD reports via SMERF on the 15th and 30th of each month
  - Review and respond to requests for DR
  - Process appeal requests for CMS review

State Responsibilities to the ERC

- Assign a state eligibility point of contact
- Participate in meetings with the ERC and CMS
  - Eligibility-specific Welcome Webinar
  - Eligibility Case Review Intake Meeting
  - System(s) Access meeting(s)
  - Regularly scheduled calls
  - Biweekly check-in meetings and other ad-hoc meetings (throughout the case review process)
- Review and/or assist with the completion of documents as requested by the ERC, including the policy survey, intake meeting protocols, and the Eligibility Case Review Planning Document
- Provide access to eligibility and documentation management systems
- Provide state eligibility policies, including eligibility processing waivers, as requested
- Provide guidance related to systems, policy, and other pertinent topics
- Assist in obtaining documentation that is not available through system access
- Review errors and technical deficiencies cited
- Submit requests for DR and appeal within the prescribed timeframes, if needed

Differences Between RY 2019 and RY 2022 Cycles

SC Processes: New to Cycle 1 States

- Data Submission Instruction Meetings
  - The SC will hold meetings to facilitate an in-depth discussion of the data submission instructions
  - Several sessions will be held in September
  - There will be sessions for both the routine PERM and PERM+ submission method
- New fields required in either the PERM+ universe submission or in the routine PERM details submission
  - Prescribing provider information (should be populated for pharmacy claims)
  - Attending provider information (should be populated for institutional claims)
  - Express Lane Eligibility (ELE) Indicator
  - Beneficiary Type (for labor/delivery payments and KICK payments)
  - Enhanced Ambulatory Patient Grouper (EAPG) Rate Code
  - Provider Location ID (for PERM+ states)

RC Processes: Difference between cycles (RY19 & RY22)

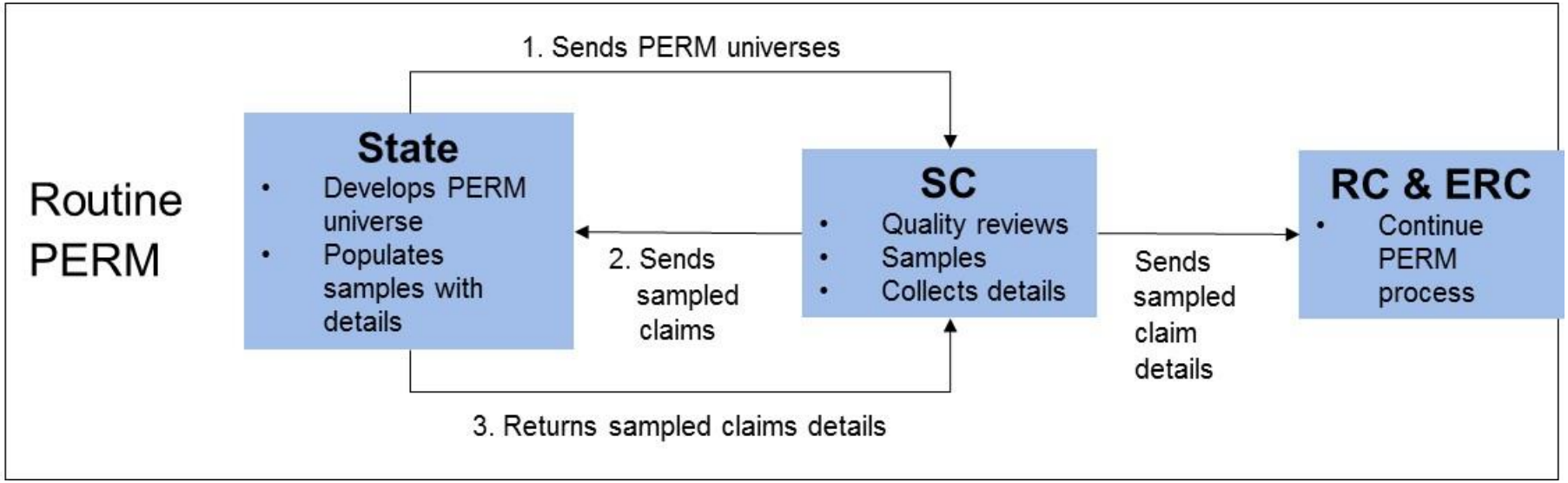
RY 2019 Cycle	RY 2022 Cycle
SMERF 2.0	Enhanced SMERF application: • SMERF now hosted by NCI instead of CNI • Increased functionality
Individual state orientation calls	Enhanced communication with states: • Individual data processing orientation with each state • Group educational webinar on medical review and medical record request processes • Individual state check-in calls, as needed
Data processing review process: • **Fewer review requirements**	Data processing review process: • Additional review requirement to verify state compliance with Fingerprint-based Criminal Background Check (FCBC) requirements for high risk providers • Case collection of review packets for all reviews
NCI completed data processing reviews, and CNI completed medical reviews	NCI will complete both data processing and medical reviews

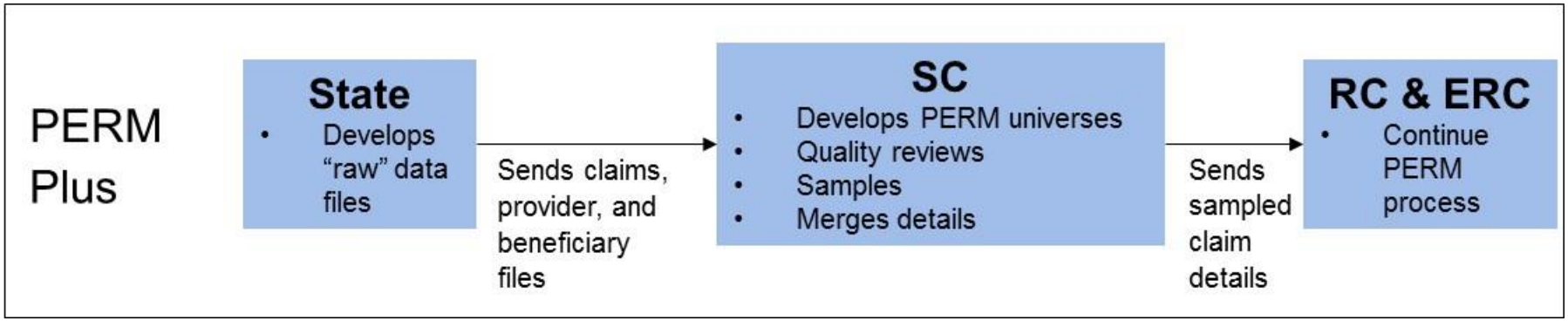
ERC Processes: New to Cycle 1 States

- Error Codes and Qualifiers
  - The ERC will use updated error codes and qualifiers for the review findings
- Review Results
  - Eligibility review findings in SMERF will now include element information

SC Process Details

SC: Universe Collection and Sampling





SC: 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

SC: Sampling

- Both FFS and managed care universes are stratified prior to sampling
- RY 2022 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., fixed payments, Medicare premiums, and Medicare crossovers)
  - Managed care is stratified into 5 dollar-weighted strata
- The SC will calculate state-specific sample sizes for each claim component in each state (final sample sizes sent to states)

SC: 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 based on the state expenditures of each program
- The claims rate is then combined with the eligibility rate

RC Process Details

SMERF

SMERF

- SMERF is the single system for the states to view data processing, medical review, and eligibility findings
- Although NCI is hosting a new version of SMERF in RY 2022, the SMERF functionality mirrors the functionality of the previous version of SMERF hosted by CNI in RY 2019
- Tracks all sampled unit workload, reviews pending information, reviews completed, and final results for all review types
- Provides real-time information on status of record requests and receipts; progress of reviews for data processing, eligibility, and medical reviews
- View eligibility, data processing, and medical review findings through the SUD reports published on the 15th and 30th of each month
- State's access includes ability to create and/or download reports, file for DR and CMS appeals, and access Final Errors For Recovery reports for recovery of overpayment errors at the end of a cycle
- Training and access to the SMERF system is provided before records are requested or reviews are started

RC: 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), including any COVID-19 related policies
- Policies accessible in SMERF system
- Upload policies into SMERF system
- Complete policy questionnaires and Master Policy Lists and submit to states for review
- Check for policy updates throughout the cycle
- Written approval of Master Policy Lists needed from states before medical review can begin

RC Data Processing Review Details

RC: State System Access

- The PERM Final Rule of 2017 requires states to grant federal contractors access to all systems that are required to facilitate the completion of reviews; including, FFS claims payments, Health Insurance Premium Payment (HIPP) payments, Medicare buy-in payments, aggregate payments, capitation payments, per member per month payments, and provider enrollment information that is not included in the payment system, and any imaging systems that contain images of paper claims and EOBS from third party payers or Medicare.
- The RC will collect documentation to support data processing reviews by directly accessing the states' systems
  - In addition, states may have to provide documentation securely, if all necessary documentation is not available via system access (e.g., paper files)
- The RC will coordinate with the states to obtain system access by:
  - Gathering information about each system from the states
  - Completing any processes necessary to access the state systems
  - Taking any required training

RC: Data Processing Reviews

- Data processing 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
- 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 data processing reviewers
  - Review RBS Assessment
  - Establish tentative dates to begin reviews
- States track pending data processing reviews through SMERF and receive automated notices for overdue pending information needed to complete reviews

RC: 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)

RC: 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 National Provider Identifier (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/RBS requirements under the ACA
  - Provider revalidation

RC: 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:
    - 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.

RC: Data Processing Reviews – Verification of Accurate Payment (cont'd)

- 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
  - The 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

RC: 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

RC Medical Review Process Details

RC: Medical Record Requests

- The RC holds medical review/medical record request orientations 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

RC: Medical Record Requests (cont'd)

- 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 Secure File Transfer Protocol (SFTP) accounts
- Incomplete documentation: Providers have 14 calendar days to send in documentation in response to additional documentation requests
  - Incomplete documentation means that a piece of documentation was not received that is necessary for the medical review to be completed
  - Specific details are provided verbally by medical reviewers and in writing for incomplete 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

RC: Medical Reviews

Orientations are held for all cycle states to include:

- Medical review process
- Medical record request process
- DR/Appeals process
- Medical review/policy questionnaire, as needed

- 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

ERC Process Details

ERC: Collection of State Policies

- Download policies from public websites (as much as possible), including any COVID-19 related policies
- Request from the state any policies that are not publicly available, including any COVID-19 related policies
- Use information gathered to populate the Policy Survey
- Submit the Policy Survey to states for review
- Check for policy updates throughout the cycle
- Upload policies into SMERF system

ERC: State 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 supporting eligibility documentation, and provider enrollment information to facilitate reviews
- The ERC will collect case documentation by directly accessing the states' systems
  - In addition, states may have to provide documentation securely, if all necessary documentation is not available via system access (e.g., paper files)
- The ERC will coordinate with the states to obtain system access; the ERC will:
  - Gather information about each system from the states
  - Complete any processes necessary to access the state systems
  - Take any required training

ERC: 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
  - State characteristics
  - State eligibility systems summary
  - State eligibility verification requirements
  - Active waiver and mitigation plans for eligibility
  - State eligibility categories and FMAP rates
  - Paper case files
  - PERM tasks and timeline
  - DR and appeals process
  - Eligibility category mapping
  - System access questionnaire
  - MAGI verification plan
  - Any additional state-specific information

ERC: 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 date of service of the sample claim
- Access and review information used by the state to process the case in the form of system screenshots 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

ERC: FMAP Collection

- The FMAP rate will be collected by the ERC to identify federal dollars assigned to a claim for each type of PERM review based on the eligibility category and the date the claim was paid

ERC: Pending Documentation 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 the documentation
  - The ERC will also answer any questions about the documentation request during the regularly scheduled check-in calls
- States will be notified of a pending documentation request via the SMERF system
- States will submit the requested documentation to the ERC via its SFTP

Best Practices

Best Practices for States: Working with the SC

- 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 SC
  - 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 SC (cont'd)

- 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 SC 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 RC

- 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 RC to explain the state's programs, data, and policies
- Establish system access for the RC
  - Identify all systems required by the RC
  - Provide all required system access forms as soon as possible
  - Designate an individual to work with RC on system access
- Provide systems training to DP reviewers
- Monitor the P1 list and provide documentation in response to the pending documentation requests timely

Best Practices for States: Working with the RC (cont'd)

- 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 data processing reviews
- 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 SC; if the state later discovers a change in the provider contacts after submitting detail data to the SC, provide the RC with updated provider contact information
- Send outreach letters to each sampled provider about the PERM program and medical record request processes before medical record requests begin
- Identify a contact person for corporate medical organizations, school systems, and state fiscal agencies

Best Practices for States: Working with the RC (cont'd)

- 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 errors (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
- Utilize the DR process to formally request repricing or, if that timeframe has expired, submit a request for repricing to the RC via email and submit appropriate documentation before cycle cut-off
- 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 ERC

- 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 the request to review the eligibility category/mapping/FMAP crosswalk
- Review and respond to questions involving the eligibility case review process

SFTP Reminder

- SFTP sites will be used to transfer data that contain PHI/PII and other relevant documentation with the SC, RC, ERC and the state
- Each contractor has a different SFTP site and will use the PERM State Contact Survey to identify state users and coordinate access
- Any state questions about either the SC, RC, or ERC SFTP should be coordinated directly with the respective contractor

Communication and Collaboration

Communication and Collaboration

- **RY 2022 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 September 23, 2020

- **Regular State Check-in calls**
  - Will be scheduled with each state by contractors

- **CMS PERM Website**
  - CMS PERM - Cycle 1
  - PERM Manual

- **PERM Corrective Action Plans - CMS Division of State Partnership**
  - PERMCAPS@cms.hhs.gov

PERM State Liaison Contact Information

Cycle 1 States	CMS PERM CAP State Liaison
Arkansas, North Dakota, Virginia	Angad Uppal Angad.Uppal@cms.hhs.gov, 410-786-1240
Connecticut, Illinois	Wendy Chesser Wendy.Chesser@cms.hhs.gov, 410-786-8519
Delaware, Kansas, Minnesota	Aileen Almario Aileen.Almario@cms.hhs.gov, 410-786-7867
Pennsylvania	Tracy Smith Tracy.Smith@cms.hhs.gov, 410-786-8418
Idaho, New Mexico	Miranda Gregory Miranda.Gregory@cms.hhs.gov, 410-786-4316
Michigan, Oklahoma	Dan Hendricks Daniel.Hendricks@cms.hhs.gov, 410-786-8925
Missouri, Wyoming	Angela Jones Angela.Jones3@cms.hhs.gov 410-786-9109
Ohio	Dan Weimer Daniel.Weimer@cms.hhs.gov, 410-786-5240
Wisconsin	Amelia Citerone Amelia.Citerone@cms.hhs.gov, 410-786-3901

SC Contact Information

The Lewin Group
PERM Statistical Contractor
3160 Fairview Park Drive, Suite 600
Falls Church, VA 22042
703-269-5500

All PERM correspondence should be directed to our central PERM inbox

PERMSC.2022@lewin.com

RC Contact Information

NCI, Inc.
PERM Review Contractor
1530 E. Parham Road
Henrico, VA 23228
800-393-3068

All PERM correspondence should be directed to our central PERM inbox

PERMRC_2022@nciinc.com

ERC Contact Information

Booz Allen Hamilton

20 M Street SE
Washington, DC 20003
Phone: 202-203-3700

All PERM correspondence should be directed to

PERM_ERC_RY2022@bah.com

Appendix: History of PERM

Legal Basis for Measuring Medicaid and CHIP Improper Payments

- The PERM program measures and reports a national improper payment rate for Medicaid and CHIP to comply with the requirements of the Payment Integrity Information Act of 2019
- 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 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 federal Fiscal Year (FY) review period to a review period of July 1 through June 30 to align with state fiscal years and to allow for additional time to complete the cycle before reporting
  - *FY to Reporting Year (RY) Naming Change*: The cycle is no longer named after the review year, but rather the year in which the results will be reported for the cycle
- *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 PERM 2017 Final Rule (cont'd)

- *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 PERM 2017 Final Rule (cont'd)

- *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 (DR)/Appeal:* Extended the DR 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