Payment Error Rate Measurement (PERM)

Introduction to PERM

May/June 2022

Centers for Medicare & Medicaid Services

Agenda

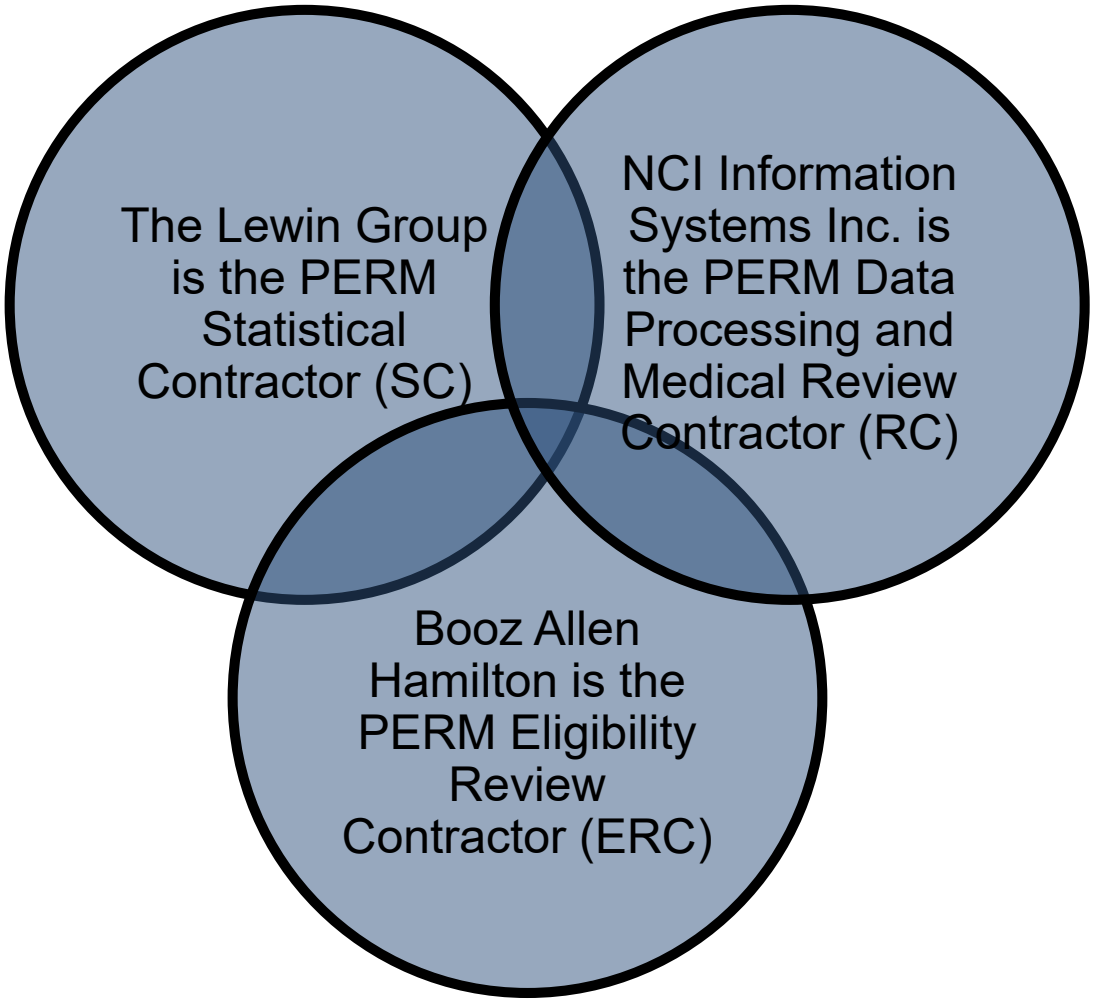
- PERM Overview
- Methodology Overview
- Roles and Responsibilities
- Differences Between RY 2021 and RY 2024 Cycles
- RY 2024 Process Details
- Best Practices
- Communication and Collaboration
- Contact Information
- Appendix: History of PERM

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.

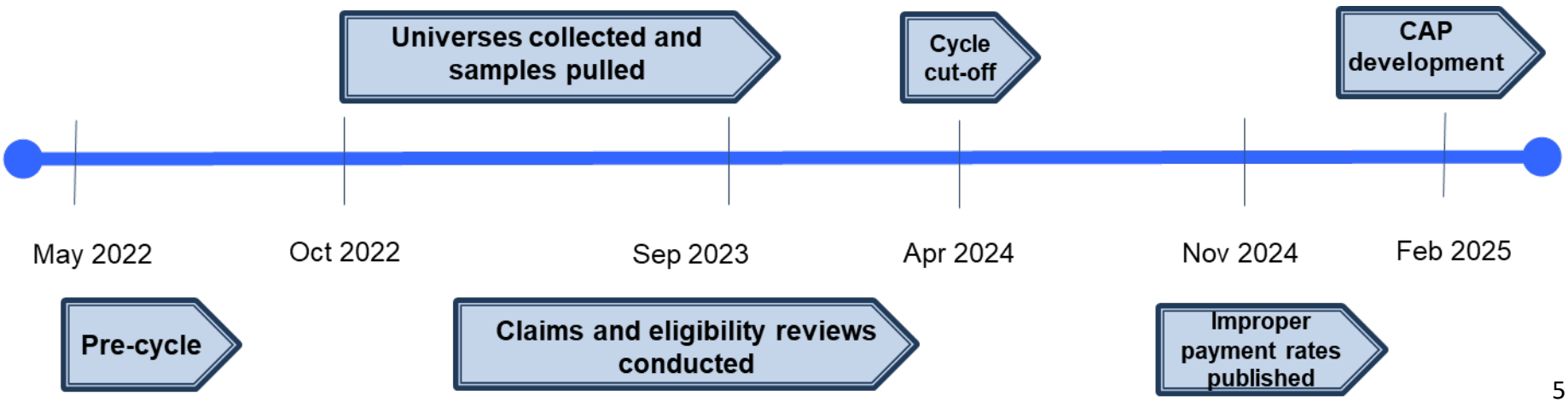
PERM Contractors



PERM Cycle Progression

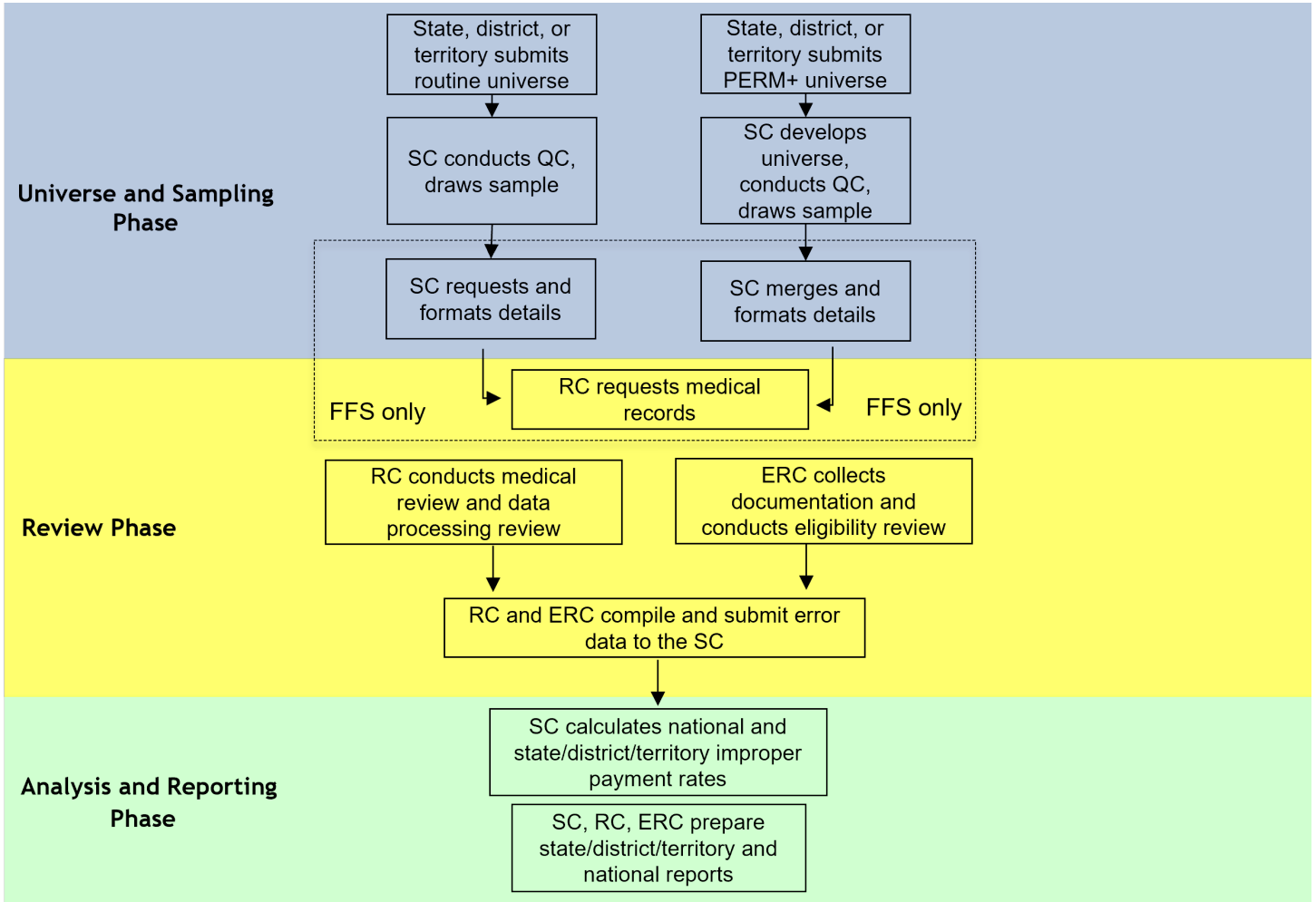
- Process of sampling, reviewing payments, calculating and reporting improper payment rates takes more than two years.
- Fee-for-service (FFS) claims and managed care capitation payments are collected for a full year – July 1, 2022 through June 30, 2023.
  - Payments receive a data processing, medical, and/or eligibility review.
  - Findings are used to calculate improper payment rates.
  - States receive findings and develop corrective action plan.

RY 2024 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- or 18-state/district/territory rotation per cycle (each state/district/territory is reviewed once every three years).
  - From within each state, district, or territory, a stratified random sample of payments is selected.
  - The sampled payments are reviewed for errors.
  - Use the findings to estimate a national improper payment rate.

Measuring Payment Errors in Medicaid and CHIP

- CMS calculates the national-level improper payment rate by using the latest improper payment rates from each state/district/territory Medicaid program and CHIP from the most current cycle and the previous two cycles.
- The national-level rate includes the most recent rates for all 50 states and the District of Columbia.

PERM State/District/Territory Rotation

Cycle	Medicaid and CHIP States Measured by Cycle
Cycle 3 (RY24)	**Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, Puerto Rico, South Dakota, Texas, Washington**
Cycle 2 (RY23)	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 1 (RY22)	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: 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 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/district/territory based on their latest expenditures and improper payment results.
- 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/district/territory when challenges occur.
- Communication and Information Sharing:
  - Host monthly cycle calls.
  - Provide guidance and technical assistance to states/district/territory throughout the process.
  - Provide educational resources for Medicaid and CHIP providers.
  - Provide direct communication and support by assigning each state, district, or territory a CMS liaison.
- Review, Resolution, and Recovery of Improper Payments:
  - Review state/district/territory-requested appeals of error findings.
  - Provide states, district, or territory with summary reports to develop corrective actions, provide assistance as they develop corrective actions, and provide them with the Final Errors for Recovery (FEFR) reports.

General State/District/Territory Responsibilities

- Overall PERM Support:
  - Provide a representative to spearhead PERM who will coordinate state, district, or territory staff and ensure essential staff attend relevant meetings, as well as provide contractors with necessary data and information and keep them apprised of any state, district, or territory issues.
  - Educate state, district, or territory 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, district, or territory-submitted data and review issues to support the PERM timeline.
  - Participate in the cycle kick-off meeting, education webinars, all-state/ district/territory 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, District, or Territory FFS and Managed Care Universes:
  - Conduct Intake Meetings with each state, district, or territory.
  - Collect paid, zero dollar paid, and denied FFS and managed care universe data from states, district, or territory on a quarterly basis.
  - Verify data documentation against data submission.
  - Perform quality control review on 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 Claims:
  - Select random samples from the universes on a quarterly basis.
  - Request sample details from states or the district 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/district/territory, cycle, and national levels for Medicaid and CHIP.
  - Conduct analysis for corrective actions.
  - Assist in preparing final reports.

State/District/Territory 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/District/Territory 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+) and payment level (Routine 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/district/territory burden.
  - Research, collect, and request Medicaid and CHIP state, district or territory policies, including relevant state regulations, program information, fee schedules, systems, and billing manuals.
  - Conduct orientations for all states, district, or territory on data processing review, medical record requests, and medical review processes.
- Conduct Data Processing and Medical Reviews:
  - Request medical records from providers.
  - Conduct case collection and data processing reviews on all sampled payments.
  - Conduct medical/coding reviews on relevant sampled FFS payments.
  - Maintain the SMERF system, conduct SMERF training webinars, and provide state/district/territory portals to track activities and findings.
  - Schedule, facilitate, and provide minutes for bi-weekly check-in calls.

RC Responsibilities (cont'd)

- Finalize Review Findings and Support Improper Payment Rate Calculation and Reporting Process:
  - Report final review findings to the state/district/territory 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 documentation for appeal requests for CMS review.
  - Notify the state/district/territory of final overpayment errors for recovery purposes at the end of the cycle after data processing, eligibility, and medical reviews are completed.
  - Compile and submit final findings to the SC.
  - Assist in preparing final reports.

State/District/Territory Responsibilities to the RC

- Support the Claims Review Process:
  - Educate providers on the PERM process and assist with medical record collection.
  - Have appropriate state/district/territory staff thoroughly complete and return questionnaires in a timely manner.
  - Assist the RC with accessing state/district/territory 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/District/Territory Responsibilities to the RC (cont'd)

- Participate in meetings with the RC and CMS, including:
  - SMERF system training.
  - Data processing orientation.
  - Medical review/medical record request orientation, and
  - State/district/territory check-in meetings.

ERC Responsibilities

- Prepare for Eligibility Case Reviews:
  - Research state, district, or territory and federal Medicaid and CHIP policies and procedures.
  - Request from the state, district, or territory any policies that are not publicly available.
  - Populate and provide the following documents to the state, district or territory for review:
    - Policy survey.
    - Intake protocol with COVID-19 Questionnaire.
    - System access questionnaire.
  - Conduct an Intake Meeting with the state, district or territory.
  - Coordinate with the states, district, or territory to obtain *remote* access to eligibility systems.
  - Provide the Eligibility Case Review Planning Document based on state/district/territory's specific systems, processes, and policies and submit to state to review for accuracy.
  - Associate state/district/territory eligibility groups with the appropriate federal group and Federal Medical Assistance Percentage (FMAP) rate and provide to state, district, or territory for review.

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/district/territory, as needed.
  - Review eligibility case actions in accordance with the federal and state, district, or territory policies.
  - Host regular biweekly check-in meetings with the state, district, or territory.
  - Coordinate with the RC when scheduling reviews, check-in meeting, and systems access training to ease state/district/territory burden when possible.
  - Support the RC by coordinating or providing available eligibility information necessary to conduct data processing reviews.
- Report Eligibility Case Review Findings:
  - Report final review findings to the states, district, or territory 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/District/Territory Responsibilities to the ERC

- Assign a state/district/territory eligibility point of contact.
- Participate in meetings with the ERC and CMS:
  - Eligibility Case Review Intake Meeting.
  - Informational Sessions on Eligibility Data for the Review Contractors.
  - System Access meetings, as needed.
  - 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, System Access Questionnaire, Eligibility Category Mapping, and the Eligibility Case Review Planning Document.
- Provide remote access to eligibility and documentation management systems.
- Provide state, district, or territory 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 2021 and RY 2024 Cycles

SC Processes: New to Cycle 3

- New fields required in either the PERM+ universe submission or in the routine PERM details submission:
  - Beneficiary Type (for labor/delivery payments and KICK payments).
  - Enhanced Ambulatory Patient Grouper (EAPG) Rate Code.
  - Emergency Service Indicator.
  - COVID-19 Indicator.

RC Processes: New to Cycle 3

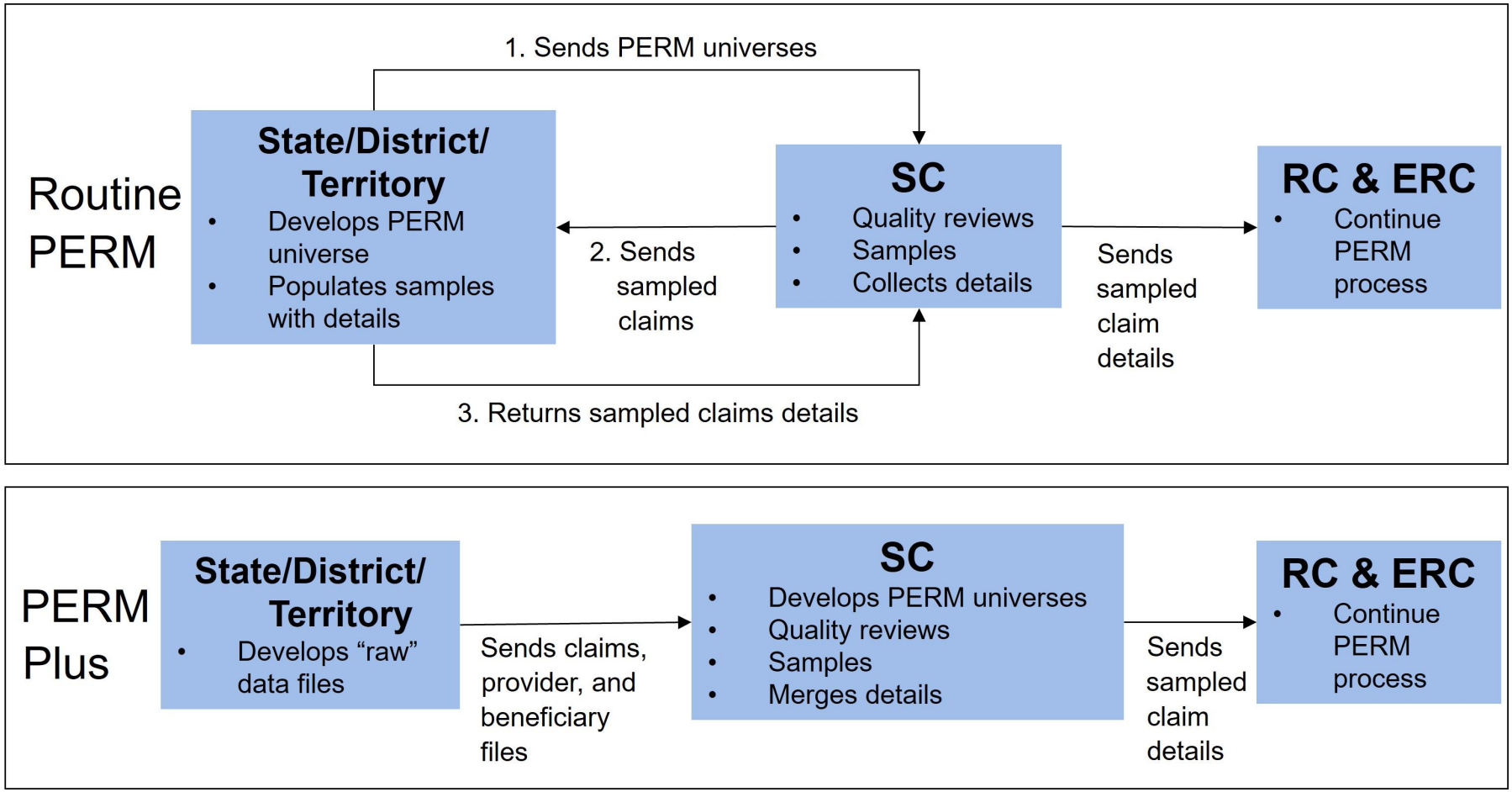
- DP reviews to start upon receipt of sampler files for some claim types:
  - Earlier focus on system access, training, and privacy/security training.
- New state/district/territory Educational Resources available under the Tools menu in SMERF:
  - Fast Fact guides on a variety of subjects: DP reviews, filing DRs, filing Appeals, secure file transfers, accessing SUD reports, etc.
- New mailbox dedicated to provider inquiries on medical record requests – PERMRC_ProviderInquiries@nciinc.com.
- New MRR address for the RC: 8701 Park Central Drive, Suite 400-B, Richmond, VA 23227 (same phone and fax numbers). The customer service line is still 800-393-3068 and the fax number is still 804-515-4220.

ERC Processes: New to Cycle 3

- Error Codes and Qualifiers:
  - The ERC will use updated error codes and qualifiers for the review findings. The ERC expects only minor changes from the RY 2021 error codes and qualifiers.
- Ongoing Documentation Submission:
  - As we did in RY21, the ERC will submit additional documentation requests to states via SMERF:
    - States, district, or territories will continue to have 30 calendar days to submit documentation.
    - If the state, district, or territory has not responded within 30 days, the ERC will move forward with completing our case review.
  - **NEW** During the RY24 cycle, states, district, or territory will be allowed to submit missing documentation for ER1, ER2, and ER3 errors throughout the cycle until cycle cut-off.
  - The ERC will review any documentation submitted and update the finding as appropriate.
- COVID-19 Public Health Emergency
  - As with any affected claims in RY 2021 towards the beginning of the PHE, the ERC will apply any COVID-19 flexibilities (i.e., SPAs, waivers) to our reviews when appropriate.
  - For RY 2024, the ERC will work with the state/district/territory to gather and understand any policy or process changes prior to beginning reviews. The ERC will provide the state with a pre-populated COVID-19 questionnaire for state review and approval as part of the Eligibility Intake Process.

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 Medicaid and CHIP service payments that are fully adjudicated by the state/district/territory that are matched by federal funds each quarter except those which are excluded.
  - 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 2024 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/district/territory-specific sample sizes for each claim component in each state/district/territory.
- Final sample sizes will be sent on May 31st.

SC: Improper Payment Rate Calculation

- For each state/district/territory, 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/district/territory expenditures of each program.
- The claims rate is then combined with the eligibility rate.

RC Process Details

State Medicaid Error Rate Findings (SMERF)

- SMERF is the single system for the state/district/territory to view data processing, medical review, and eligibility findings.
- 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 and 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/district/territory access includes ability to create and/or download reports, file for DR and CMS appeals.
- Training and access to the SMERF system is provided before records are requested or reviews are started.

RC: Collection of State/District/Territory Policies

- Send initial email to state/district/territory prior to implementation:
  - Explain policy collection process and timeframes.
  - Establish policy contacts with each state/district/territory.
- Collect policies from state, district, or territory websites (as many as publicly available), including any COVID-19 related policies.
- Submit policy questionnaires and Master Policy Lists to state/district/territory for review and updates.
- Confirm Master Policy List is comprehensive and complete before medical review.
- Upload policies into SMERF system.
- Check for policy updates throughout the cycle.

RC Data Processing Review Process Details

RC: Remote 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 state/district/territory systems.
  - In addition, state/district/territory 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 state, district, or territory to obtain system access by:
  - Gathering information about each system from the state/district/territory.
  - Completing any processes necessary to access the state, district, or territory 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/district's/territory's claims processing system and provider files.
- Data processing webinars are scheduled with each state/district/territory prior to reviews.
  - Review state/district/territory system(s) questionnaire completed by states/ district/territory.
  - Review any special programs (waivers, etc.).
  - Determine and gather desk aids, manuals, and website links needed for training data processing reviewers.
  - Review RBS Assessment.
  - Establish tentative dates to begin reviews.
- State/district/territory 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).
  - 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.
- The data processing team 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 independently price each sampled payment manually to determine if the payment was made in accordance with published state/district/territory policies and rates in effect for the dates of service under review.
- Reviewers will need access to the rates that were in effect for the dates of service for claims under review, including those housed outside of MMIS.
- Reviewers will also need:
  - Information about how the state/district/territory 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 the states/district to review the medical record request processes before starting calls to providers.
- The RC uses the provider and MR point of contact information received in the details files submitted by the states/district to contact providers and send request letters.
- Provider information is verified during the initial live call. If the provider cannot be reached, state/district 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 is sent to providers via certified mail if no MR documentation has been received. MR1–*No Documentation* error is cited if no records are received.
  - If documentation is submitted and is missing information, the RC sends an additional documentation request (ADR) letter to the provider.
- Providers have 14 calendar days to send in documentation in response to additional documentation requests (ADR):
  - Reminder calls/letters are sent at 7 days if an ADR response was not received.
  - If no ADR response is received, a 15-day non-response letter is sent. MR2–*Document Absent from the Record* error is cited is documents are missing from the record.
  - If an ADR response is received but does not include all the requested items, an Incomplete Information letter is sent to the provider specifying the missing item(s) and an MR2 error is cited.
- States receive copies of all letters to providers on a weekly basis via the RC's SFTP.
- Late documentation for MR1/MR2 errors can be accepted until the cycle cut-off date.

RC: Medical Reviews

Orientations are held for all cycle states and district 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 state/district, records submitted by providers, and collected state/district policies.
- Validates whether the claim was paid correctly by assessing the following:
  - Adherence to federal and state/district 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 Eligibility Review Process Details

ERC: Collection of State/District/Territory Policies

- Download policies from public websites (as much as possible), including any COVID-19 related policies.
- Request from the state, district, or territory 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, district, or territory for review.
- Check for policy updates throughout the cycle.
- Upload policies into SMERF system.

ERC: State/District/Territory Remote System Access

- The PERM Final Rule of 2017 requires states, districts, or territories 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 state/district/territory systems.
  - In addition, states, districts, or territories may have to provide documentation via the ERC's SFTP if all necessary documentation is not available via system access (e.g., paper files).
- The ERC will coordinate with the states, districts, or territories to obtain system access by:
  - Gathering information about each system from the states, districts, or territories.
  - Completing any documents, such as data use agreements and system access forms, necessary to access the state/district/territory systems.
  - Taking any required trainings.

ERC: Eligibility Case Review Planning Document

- The purpose is to have a shared document among the state/district/territory, 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/district/territory, CMS, and ERC points of contact.
  - State/district/territory characteristics.
  - State/district/territory eligibility systems summary.
  - State/district/territory eligibility verification requirements.
  - Active waiver and mitigation plans for eligibility.
  - State/district/territory eligibility categories and FMAP rates.
  - Paper case file collection process.
  - PERM tasks and timeline.
  - DR and appeals process.
  - Eligibility category mapping.
  - System access questionnaire.
  - MAGI verification plan.
  - COVID Questionnaire.
  - Any additional state/district/territory-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 prior to the date of service; and
  - Any changes in circumstance that required an action if it occurred prior to the date of service of the sample claim.
- Access and review information used by the state/district/territory 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/district/territory policies in place at the time of the action under review 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 state/district/territory to provide the documentation.
  - The ERC will also answer any questions about the documentation request during the regularly scheduled bi-weekly check-in calls.
- States, districts, or territories will be notified of a pending documentation request via the SMERF system.
- States, districts, or territories will submit the requested documentation to the ERC via its SFTP within the requested timeframe.
- Note: During the RY24 cycle, states, district, or territory will be allowed to submit missing documentation for ER1, ER2, and ER3 errors throughout the cycle until cycle cut-off.

ERC: Eligibility Data Transfer to the RC

- Eligibility source information will be gathered by the ERC via screen-prints or sent by the state via a data extract to assist the RC with data processing reviews.
- Informational Sessions, hosted by the ERC, will be scheduled with all cycle states in August 2022 for more information on this process.

Best Practices

Best Practices for State/District/Territory: Working with the SC

- Assign a dedicated contact person for all communications.
- Include relevant staff in all PERM 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.
  - The universe build and payment level meeting should include all relevant staff.
- 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:
  - State/district/territory should perform quality checks to make sure data fields are uniformly populated with valid values.
  - State/district/territory 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 any additional variables included in the data submission to assist state staff or the SC in identifying correct claims.

Best Practices for State/District/Territory: 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/district/territory transmission each quarter:
  - Identify the relevant staff who are involved in the data analysis portion of the project and involve them from the start of the cycle.
- 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.

Best Practices for State/District/Territory: Working with the SC (cont'd)

- 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.
- Establish a stream of communication or dialogue from the beginning of the cycle with your SC contact.
- Ask questions proactively.
- Have helpful information related to PERM readily available to share with your staff:
  - SC contact list.
  - Data submission instructions.
  - Details submission instructions.

Best Practices for State/District/Territory: 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/district/territory programs, data, and policies.
- State/district/territory subject matter experts from the appropriate state departments attend and participate in check-in calls.
- Complete and return questionnaires promptly and thoroughly.
- Establish system access for the RC early:
  - 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.
  - Identify all security/privacy training reviewers will need to complete.
- Provide systems training to DP reviewers.
- Monitor the data processing P1 list and provide documentation in response to the pending documentation requests timely.

Best Practices for State/District/Territory: Working with the RC (cont'd)

- If the state/district/territory 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, district, or territory submits quarterly detail data to the SC. If the state, district, or territory 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 State/District/Territory: 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.
- Use the Advanced Error Notice notification from SMERF to 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 State/District/Territory: Working with the ERC

- Engage a cross-functional state/district/territory PERM eligibility team that includes policy, systems, claims, program integrity, IT, and operations:
  - Ensure appropriate team members attend biweekly check-in calls.
- Establish remote system access for the ERC:
  - Identify all systems required by the ERC.
  - Provide all required system access forms or data use agreements 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 Intake Protocol, System Access Questionnaire, and Eligibility Category/FMAP crosswalk.
- Review, ask, 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/district/territory.
- Each contractor has a different SFTP site and will use the PERM State/District/Territory Contact Survey to identify state users and coordinate access.
- Any state, district, or territory questions about either the SC, RC, or ERC SFTP should be coordinated directly with the respective contractor.

Communication and Collaboration

Communication and Collaboration

- **RY 2024 PERM Cycle 3 Calls:**
  - The cycle calls will occur on fourth Tuesday of each month from 3:00 – 4:00 pm Eastern Time.
  - First cycle call will be held on May 24, 2022.

- **Regular State/District/Territory Check-in calls:**
  - Will be scheduled with each state/district/territory by contractors.

- **CMS PERM Website:**
  - CMS PERM - Cycle 3.
  - PERM Manual.
  - PERM RY 2024 Cycle 3 Kick-off Presentation.

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

PERM State/District/Territory Liaison Contact Information

Cycle 3 States	CMS PERM CAP State Liaison
Alaska, Arizona	Ray Antoine Ray.Antoine@cms.hhs.gov
District of Columbia, Mississippi	Wendy Chesser Wendy.Chesser@cms.hhs.gov
Florida, Maine	Aileen Almario Aileen.Almario@cms.hhs.gov
Hawaii, Louisiana	Jailynne Price Jailynne.Price@cms.hhs.gov
Indiana, Texas	Elise Hanks-Witaszek Elise.HanksWitaszek@cms.hhs.gov
Iowa, Montana	Caitlyn Brown Caitlyn.Brown@cms.hhs.gov
Nevada	Daniel Weimer Daniel.Weimer@cms.hhs.gov
New York, South Dakota	Misha Patel Misha.Patel@cms.hhs.gov
Oregon, Puerto Rico	Angela Jones Angela.Jones3@cms.hhs.gov
Washington	Anita Moore Anita.Moore@cms.hhs.gov

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.2024@lewin.com

RC Contact Information

NCI Information System, Inc.
PERM Review Contractor
8701 Park Central Drive, Suite 400-B
Richmond, VA 23227

CSR Telephone Line: 800-393-3068

Direct general inquiries to our central PERM inbox:
PERMRC_2024@nciinc.com

Direct SMERF access inquiries to:
SMERFaccounts@nciinc.com

Send **inquiries** about documentation to:
PERMRC_DOCS@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_RY2024@bah.com