CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Payment Error Rate Measurement (PERM)

RY 2026
Cycle 2
Kick-Off

April 18, 2024

Agenda

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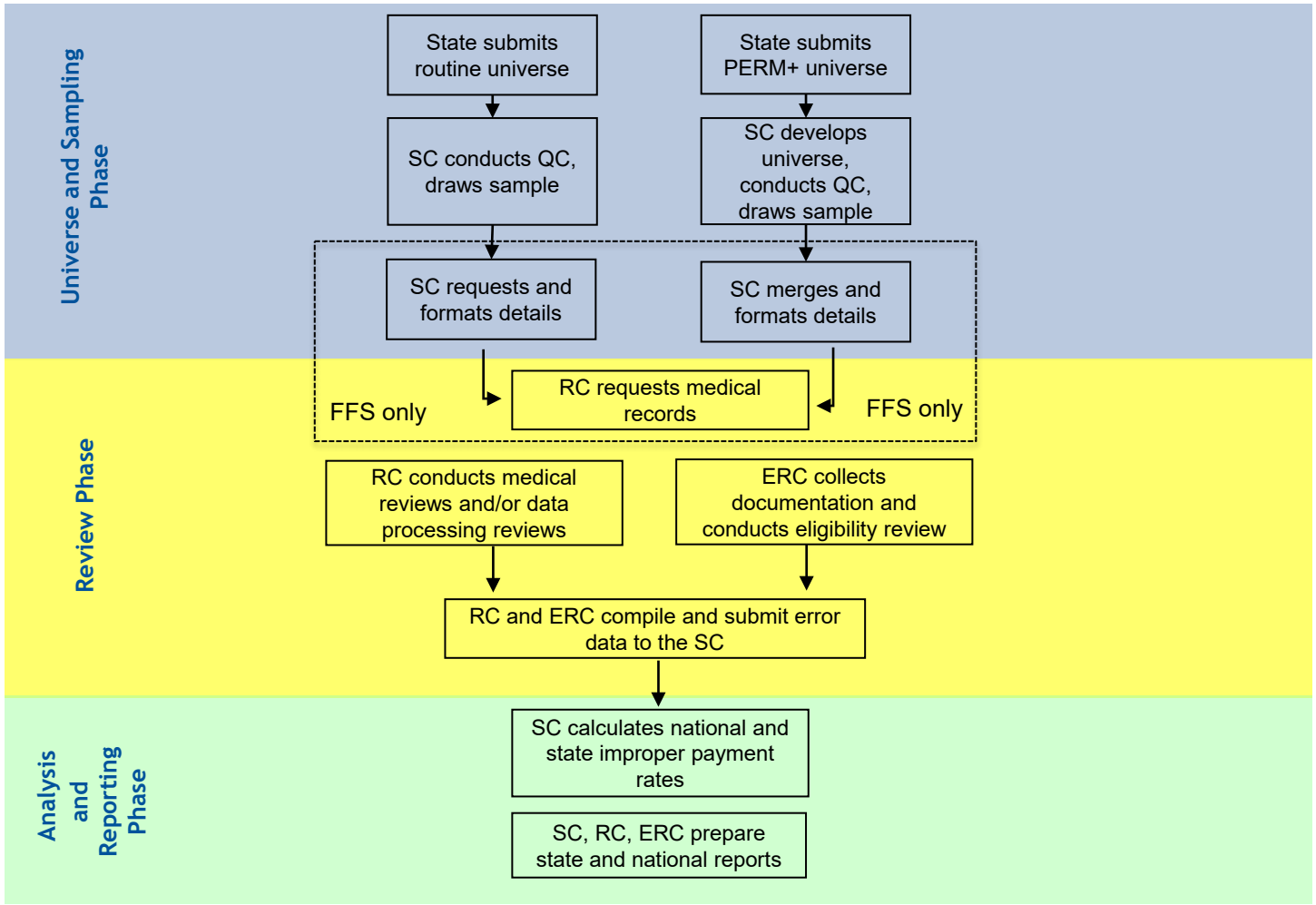
PERM Program Overview

- CMS is required to estimate the amount of improper payments in Medicaid and the Children's Health Insurance Program (CHIP) annually, as required by the Payment Integrity Information Act (PIIA) of 2019.
- 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 samples a small subset of payments for review and extrapolates the results to the "universe" of payments.
- The program is operating under the PERM final regulation published on July 5, 2017.
- This cycle will review Medicaid and CHIP payments made in Reporting Year (RY) 2026 (**July 1, 2024, through June 30, 2025**).
- The RY 2026 improper payment rates will be reported in the HHS Agency Financial Report (AFR) published in November 2026.

PERM Program Overview: Cycle Progression

Claims and Payment Measurement



Statistical Contractor (SC)
The Lewin Group

SC:
The Lewin Group

- The Lewin Group is the PERM SC for RY 2026 and has experience working with the last 13 PERM cycles.
- The SC collects Medicaid and CHIP payments on a quarterly basis and selects samples for DP, MR, and ER.
- Prior to receiving data, the SC will hold Intake Meetings with each state to gather information regarding state Medicaid and CHIP data, payment structure, and programs.

SC: Claims Data Submission

- States must submit valid, complete, and accurate claims universes to the SC.
- States have three data submission options – **must choose by May 31, 2024:**
  - Routine PERM.
  - PERM+.
  - Hybrid
    - For more information on the submission options, contact PERMSC.2026@lewin.com.
- An Intake Meeting is held with each state to discuss:
  - Requirements of PERM claims data submission.
  - Medicaid and CHIP programs and payment structures.
  - All data sources and the data collection process for PERM.
  - Waivers, demonstrations, and other programs in the state.
  - Any state-specific considerations around staffing structure and processes.

SC: Claims Data Submission (cont'd)

- 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 early June.
  - There will be sessions for both the routine PERM and PERM+ submission methods.

SC: Claims Data Submission (cont'd 2)

- Revised Intake Meeting Process
  - The SC will provide the state with responses to intake questions from the prior cycle and give states the opportunity to provide updates.
  - The SC will focus on questions about required data fields to be included in state submissions, formatting options, and file layouts (planned to take place in June and July 2024).
  - States will be required to submit file layouts mapping their data variables in state system(s) to variables requested for PERM following the data Intake Meeting.
  - The SC will review PERM requirements with the state's data team.
    - In-depth review of state file layouts—variable by variable—to confirm correct data is mapped to the required and proper fields.
    - Note challenges/missing information from the state.
    - Walk through any potential data merging issues with PERM+ states.
    - Discuss header versus line data submission and payment levels.
    - Address any PHI/PII concerns.
    - Introduce PERM SFTP access, setting up credentials, and security protocols.

SC: Claims Data Submission (cont'd 3)

- CMS-64/21 Intake Meeting
  - CMS-64/21 Intake Meetings will include the PERM contacts and the state's financial staff (planned to take place in July and August 2024).
    - Introduce the CMS-64/21 comparison and reconciliation process as part of the PERM program.
    - Discuss the expected timeline for completion of this process.
    - Walk through a sample of the financial summary documents that will be prepared for each state program.
    - Review the state's comparison and reconciliation process from the previous PERM cycle.
    - Answer any questions that the state staff may have regarding this process.
    - It is vital that the state has the correct participants on the call to ensure that all required data are submitted and included in the appropriate universe.

SC: Claims Data Submission (cont'd 4)

- Claims data due dates:

Quarter	Paid Date	Due Date
Quarter 1	July 1 – September 30, 2024	October 15, 2024
Quarter 2	October 1 – December 31, 2024	January 15, 2025
Quarter 3	January 1 – March 31, 2025	April 15, 2025
Quarter 4	April 1 – June 30, 2025	July 15, 2025

- The SC will work with the state to ensure all PERM submission requirements are met each quarter.
  - Timely communication and efforts early on in the cycle will help the process for subsequent quarters and phases of PERM.
- The SC performs a series of quality control checks on the data.
- The SC also performs a comparison of PERM data submission to CMS-64/21 reports but encourages states to perform similar work as data is submitted to ensure all required data are submitted and included in the correct universe.

SC: Claims Data Submission (cont'd 5)

- There are some fields that will be mandatory in the universe submission for eligibility reviews: Beneficiary ID, Gender, Date of Birth, County/Service Area, and Eligibility Category.
- **New** Additional Universe Field Required to Support Reviews:
  - Capitation Reason Code.
- The final data submission instructions will be sent out in May 2024.

SC: FFS and Managed Care Sampling

- PERM will utilize sample sizes that cap the number of samples selected from FFS and MC for MR, DP, and ER.
- The national sample size will be distributed across states based on the latest state expenditures.
- Each state will receive its sample size notification by May 31, 2024.

SC: FFS and Managed Care Sampling (cont'd)

- Payment Stratification Sampling:
  - In RY 2026, for FFS, the SC will use five payment strata and one stratum for claims that receive only a data processing review, including fixed, aggregate, and Medicare Crossover payments; for managed care, there will be five payment strata.
  - Note that eligibility samples will be divided among FFS and MC universes. Claims and eligibility sample selection are nested; therefore, eligibility samples will be drawn from the same FFS and MC universes.

SC: FFS Details Data

- Details data are used to request medical records, conduct medical review, conduct data processing review, and conduct eligibility review for sampled FFS claims.
  - Submitted by routine PERM states.
  - SC creates details file for PERM+ states.
- As in RY 2023, the SC will hold details Intake Meetings with each routine PERM state to:
  - Provide an overview of the details data requirements.
  - Discuss details Intake Protocol.
- Details Intake Meetings will also be held with each PERM+ state to:
  - Review details built by the SC.
  - Verify information to support medical record request and eligibility review.
- The SC performs a series of quality control checks and sends questions on any missing/incomplete/invalid information to the states.
- The SC may require regular meetings to resolve data issues if there are significant complications or delays.

SC: FFS Details Data (cont'd)

- Provider Fraud Indicator:
  - The state should review the providers for all sampled claims to see if they are under an active fraud investigation.
  - If any of the sampled claims are for providers under fraud investigation and the state does not want PERM to contact the provider, it should notify the SC of the impacted PERM IDs as soon as possible.
  - The RC will not contact any providers that are flagged in the completed details file and will cite the associated claims as MR1 errors later during the review phase.
  - Claims associated with these providers will be represented as no documentation improper payments in the state's rate.
  - If at any point in the cycle a fraud suppression is lifted, please notify the SC immediately of the impacted PERM IDs.

SC: FFS Details Data (cont'd 2)

- Medical Records Contacts:
  - To expedite return of medical records, states should provide medical records contact names and addresses in either the universe data (PERM+) or details (routine PERM).
  - Please review the address information available in your state systems ahead of universe or details submission to ensure the correct information is being provided. This could be reflected in the Correspondence or Mailing Address fields.

Review Contractor (RC)
Empower AI, Inc.

RC
Empower AI, Inc.

- Empower AI, Inc. is the PERM RC for RY 2026 and has worked the last six PERM cycles.
- The RC is responsible for:
  - Hosting and maintaining SMERF.
  - State policy collection and creation of state Master Policy Lists (MPLs).
  - Conducting DP reviews.
  - Sending MRR.
  - Conducting MR.

*Note: The RC underwent a name change from AdvanceMed, to NCI Information Systems, Inc, and now to Empower AI, Inc. The domain for logging in to the SMERF platform remains admedcorp.com; however, the email domain for the RC is @empower.ai.

RC: SMERF Access

- The RC hosts and maintains SMERF.
- RY 2023 returning state users will need to request a password reset if their account is not currently active.
- Send access requests for new state users and password resets for returning state users to SMERFaccounts@empower.ai

RC: State Policy Collection

- The RC develops state-specific MPLs of all Medicaid and CHIP policies for the current cycle.
- The RC collects Medicaid and CHIP payment and medical policies from state websites including policy waivers/flexibilities related to the COVID-19 Public Health Emergency (PHE).
- The RC may also collect state plan amendments, administrative codes and regulations, provider manuals, bulletins, updates, fee schedules, code lists, etc.
- States complete questionnaires to provide policy clarification in areas applicable to MR and DP reviews (planned to take place in October/November 2024).
- States must review and verify that the MPL is complete and provide policies the RC is unable to collect and download from state websites (planned to take place in January/February 2025).
- The RC continues policy collection throughout the cycle and incorporates updates as applicable.
- DP and MR policies will be available to states in the SMERF system to access when an error is cited.

RC: DP Reviews

- The RC conducts DP reviews 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, state policies, and supporting documentation.
- The RC collects case information called review packets for **every** DP review (not just errors).
- Discussions on state requirements for remote systems access for DP reviewers will occur very early in the cycle.

RC: DP Reviews (cont'd)

- DP reviews begin with receipt of the detail files from the SC.
- DP reviewers must have remote systems access before the SC sends the first detail files.
- The RC and ERC may seek remote access concurrently but for different state systems.
- The RC will send DP questionnaires and Risk-based Screening (RBS) assessments to states for completion (planned to take place in November 2024).
- The RC conducts a DP Orientation webinar on three separate dates that allows states to choose their participation date (planned to take place in December 2024).
- Individual DP meetings with the states will occur after the questionnaire responses are received and prior to starting reviews (planned to take place in January/February 2025). Applicable policy waivers or flexibilities from the PHE will be discussed during this meeting. The RC completes and sends the state's DP review checklist after the meeting to assist in review preparation.

RC: DP Reviews (cont'd 2)

- The RC will coordinate and review RBS test cases from states.
- The RC gathers desk aids, manuals, and website links needed for training DP reviewers and completing DP reviews.
- The ERC team gathers and shares eligibility documentation with the DP team to avoid duplication of effort.
- States may access Fast Facts desk aids available in SMERF on a variety of DP review topics via SMERF > Tools > State Educational Resources.

RC: DP Reviews (cont'd 3)

- The RC holds biweekly check-in calls with each state throughout the cycle to discuss system access, status of reviews, reviews on the pending (P1) list, errors cited, policy clarifications, etc. (RC biweekly check-in calls begin when the RC starts reviews for the state).
- States track the P1 list in real time through SMERF and receive automated notices for overdue information.
- Claims on the P1 list may be converted to errors if needed documentation is not provided by the state within 14 days.
- All errors identified on a claim will be cited and reported (multiple errors are possible on a single claim).
- If needed, the RC can provide additional information/training on the elements of a DP review.

RC: DP Reviews - FFS Review Elements

- **Beneficiary (verification from eligibility source system):**
  - Demographics.
  - Eligibility for service based on aid category and benefit plan.
  - Managed care participation.
  - Patient liability.
  - Medicare and/or other insurance coverage, Third-party Liability (TPL).
- **Provider enrollment:**
  - RBS compliance.
  - Licensure verification.
  - Clinical Laboratory Improvement Amendments (CLIA) verification, as applicable.
- **Payment accuracy:**
  - Timely filing.
  - Pricing.
  - Health Insurance Portability and Accountability Act (HIPAA) 5010 adherence for dates of service (DOS) on/after 7/1/2012.
  - Claim is complete and accurate.
  - Prior authorization.

RC: DP Reviews - Managed Care Review Elements

In addition to all beneficiary information examined under FFS review, reviewers also examine:

- Managed care sample contract.
- Health plan information.
- Capitation rates and rate cells.
- Capitation payment history screens to check for duplicate payments/adjustments.
- Geographical service areas (counties, ZIP code).
- Exclusions, population, and service carve-outs.
- Adjustments to paid amount.

RC: DP Reviews: Preliminary RY 2026 DP Finding Codes

Code and Definition	Code and Definition
C1 – Correct	**P1** – Pending Information from State
DP1 – Duplicate Claim	**DP8** – Managed Care Rate Cell
DP2 – Noncovered Service/Beneficiary Eligibility/MMIS System Error	**DP9** – Managed Care Payment
DP3 – FFS Payment for a Managed Care Service	**DP10** – Provider Information/Enrollment
DP4 – Third-Party Liability (TPL)	**DP11** – Claim Filed Untimely
DP5 – Pricing	**DP12** – Administrative/Other

RC: MRR

- The RC has primary responsibility for obtaining medical records from providers.
- Unless an MRR point of contact (POC) is specified by the state in the details data sent to the SC, the RC sends MRR requests to the billing provider.
- The RC asks states to identify a new POC or contact providers who are not responding as needed.
- The RC notifies state PERM representatives when the MRR process begins (MRR process begins after RC receives details file from the SC).
- RC Customer Service Representatives (CSRs) validate the providers' contact information by phone before sending record request letters.
  - Providers have **75 days** to submit documentation.
  - Providers may send documentation by fax, by mail, or if using a Health Information Handler (HIH), by CMS' Electronic Submission of Medical Documentation (esMD) system.
- CSRs make reminder calls and send follow up letters after 30, 45, and 60 days (unless received).
  - RC sends non-response letters on day 75 via registered mail resulting in MR1 errors.

RC: MRR (cont'd)

- If submitted documentation is incomplete, the RC sends an additional documentation request (ADR) letter.
  - The provider has **14 days** to submit additional documentation.
  - CSRs make a reminder call and send a follow up letter if pending after 7 days.
  - If the provider does not respond, the RC sends a non-response letter after 14 days resulting in a system generated MR2 error - Document(s) Absent from Record.
- If an ADR response is received but determined to be incomplete, the RC sends an Incomplete Information Letter specifying what is missing; this also results in an MR2 error (states receive a related PERM alert – Insufficient Information Documentation Request).
- If the RC receives records of poor quality or with other issues, the RC sends a Resubmission Letter detailing the issue; an MR1 error will result if the provider does not respond.

RC: MRR (cont'd 2)

- If a provider sends documentation to the state rather than the RC, the state may submit the documentation to the RC using the established SFTP account (Kiteworks).
- The RC does not contact providers with claims suppressed for potential fraud; this results in MR1 errors with a qualifier for provider under investigation.
- If a change to the fraud suppression list is required during the cycle, contact the SC and include the RC on the notification once the state identifies a change is required.
- Every Friday, the RC sends the state copies of all letters sent to the providers during the week.
- Providers may submit missing documentation for MR1 and MR2 errors until the cycle cut-off date.
- CSRs will continue to call providers with MR1/MR2 errors that have a high impact on improper payment rates.
- State involvement is essential in obtaining necessary documentation from providers.

RC: MR

- The RC conducts MR on sampled FFS claims only.
- Each state receives an MRR/MR policy questionnaire to be completed and returned to the RC (planned to take place in October 2024); follow-up meetings will be scheduled as needed to include discussion of COVID-19 policy changes.
- States participate in MRR/MR orientations (planned to take place in March 2025) hosted by the RC covering:
  - The MRR process.
  - The MR process.
  - Filing DRs and appeals.
- MR utilizes claims data submitted by states, records submitted by providers, federal regulations, and collected state policies to inform the review decisions.

RC: MR (cont'd)

- Reviewers validate if the claim was paid correctly by assessing:
  - Adherence to federal regulations and the state's 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.
- The RC regularly sends the state, via Kiteworks, a copy of the medical records for each error that will post on the upcoming Sampling Unit Disposition (SUD) report; this allows the state to research prior to the SUD if a DR will be filed once the SUD is published.
- During the biweekly check-in calls, the RC advises states of the volume of reviews completed, the number and types of errors cited, any questions on policies, pending DRs, or re-pricing requests, etc. (RC biweekly check-in calls begin when RC starts reviews for the state).

RC:
Preliminary RY 2026 MR Finding Codes

Code and Definition	Code and Definition
C1 – Correctly paid	**MR 6 –** Number of Unit(s) Error
MR 1 – No Reviewable Documentation Received Error	**MR 7 –** Medically Unnecessary Service Error
MR 2 – Document(s) Absent from Record Error	**MR 8 –** Policy Violation Error
MR 3 – Procedure Coding Error	**MR 9 –** Improperly Completed Documentation Error
MR 4 – Diagnosis Coding Error	**MR10 –** Administrative/ Other Error
MR 5 – Unbundling Error	

Eligibility Review Contractor (ERC)
Booz Allen Hamilton

ERC

- Booz Allen Hamilton, along with Myers and Stauffer LC and The Rushmore Group, constitute the PERM ERC team for RY 2026 and has worked the last nine PERM cycles.
- The ERC:
  - Performs PERM eligibility reviews for all states and brings state-specific knowledge of eligibility systems and processes, while being well-versed in state and federal Medicaid and CHIP eligibility policy.
  - Conducted PERM eligibility reviews for the Cycle 2 states in RY 2020 and RY 2023.
- The ERC will:
  - Provide eligibility data to support the RC in DP reviews.

Overview of Eligibility Reviews

- The eligibility case review focuses on whether a determination—new application or redetermination—was processed correctly based on the federal and state eligibility policies in place at the time of the action.
- The ERC reviews the action on a case that made the individual eligible on the sampled claim's DOS.
- To conduct reviews, the ERC will:
  - Research federal and state Medicaid and CHIP policies and procedures.
  - Coordinate with the state to obtain remote access to eligibility systems.
  - Access and review information used by the state to process the case, including system screen prints and case documents that support the eligibility determination.
  - Review eligibility elements against federal and state policies to determine if the case is correct or if a payment error should be cited.
  - Request additional documentation and report findings to the state via SMERF.

ERC State Eligibility Policy Collection

- The ERC will use previously provided policy documentation and download updated eligibility policies from public websites, when available.
- States will provide the ERC with any eligibility policies that are not publicly available.
- The state will review the Eligibility Policy Survey that is populated by the ERC. The policy survey identifies federal and state policies that will be used during the eligibility reviews. The state will provide policy updates as available throughout the cycle to minimize questions from the ERC and avoid delays.
  - Note: The ERC always uses the policies in place at the time of the determination under review, including if case actions occurred during the COVID-19 PHE unwinding period.

Federal Medical Assistance Percentage (FMAP)

- During the eligibility review intake process, the ERC will provide each state their category mapping with the state's eligibility categories and the associated system codes. The states Subject Matter Experts (SME) should make the necessary updates and changes to the RY 2023 document to ensure it is current for RY 2026 reviews.
- The FMAP rates will be used to identify federal dollars assigned to a claim for each type of PERM review based on the category of eligibility and date of payment.

Example of Eligibility Review Elements

The eligibility review consists of evaluating the following eligibility elements, as appropriate, to determine the element was verified and recorded, and used appropriately in making an eligibility determination in accordance with federal and state policies:

- Age
- Citizenship
- Immigration Status
- State Residency
- Social Security Number
- Pregnancy
- Household Size
- Tax Filer Status
- Income
- Resources/Assets (Non-MAGI)
- Blindness, Disability, Medical Eligibility
- Health Insurance (CHIP)
- Medicare enrollment
- Signature under Penalty of Perjury on Application/Renewal
- Timely Redetermination

The ERC will collect documentation that these elements were verified, including data matches, hard copy verifications, telephonic recordings, etc.

Pending Documentation Requests

- Upon the ERC's initial review of the information collected, the ERC may identify cases with missing information and will use the SMERF system to request additional documentation from the state, which can be tracked through the eligibility pending (EP1) list.
  - States should leverage regularly scheduled check-in calls with the ERC to ask any questions about the requests. The state will submit the requested documentation to the ERC via SFTP.
- In addition to the ADR process, states can provide additional documentation used in the determination for ER1s, ER2s, and ER3s as part of an "ongoing documentation collection" process during reviews and prior to cycle cut-off. If states identify missing documentation after the standard ADR period, this ongoing documentation collection process opens another avenue to submit documentation to address an error prior to cycle cut-off.

Pending Documentation Requests (cont'd)

- **NEW** Independent Verification Process
  - In addition to the ADR process for RY 2026, to determine beneficiary eligibility when there is insufficient documentation, the ERC is asking states to allow the ERC to obtain access to state verification systems that allow them to independently verify the eligibility of the beneficiary. The ERC will look for any information that supports beneficiary eligibility despite verification documentation.
- The ERC will provide more detail on this process during and following the Eligibility Intake Meetings planned for this fall.

Eligibility Reviews

Code and Definition	Code and Definition
C1 – Correct	**EP1 –** Pending information from state
ER1 – Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	**ER6 –** Should have been enrolled in a different program (i.e., Medicaid or CHIP)
ER2 – Verification of eligibility element not done/required documentation not collected at the time of determination; unable to determine beneficiary eligibility	**ER7 –** Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment
ER3 – Determination not conducted as required; unable to determine beneficiary eligibility	**ER8 –** Not eligible for enrolled eligibility category; ineligible for service provided
ER4 – Not eligible for enrolled program (i.e., Medicaid or CHIP) – financial issue	**ER9 –** FFE-D Error
ER5 – Not eligible for enrolled program (i.e., Medicaid or CHIP) – non-financial issue	**ER10 –** Other Errors

Remote System Access and State Participation

Remote Systems Access

- The PERM Final Rule (published on July 5, 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.
- All RY 2026 DP and ERC reviews will be conducted through secure, remote system access.
- Granting ERC and RC access to relevant systems facilitates reviews with the goal of reducing state burden.
- The ERC and RC will collect case documentation through direct access to the state systems.
  - The state may have to provide additional documentation securely, if all necessary documentation is not available via system access (e.g., paper files).

Remote Systems Access (cont'd)

- During the next few months, the ERC and RC will coordinate with the state directly to obtain system access; the ERC and RC will:
  - Gather information for each system from the state.
  - Execute any data use agreements (DUAs) or other required agreements that are necessary to access the state systems.
  - Take any required training.

Overview of State Participation in PERM Reviews

- In support of RY 2026 reviews, states will:
  - Plan for and establish secure, remote system access for the ERC and RC early in the cycle.
  - Coordinate scheduling of and participation in Intake Meetings.
  - Update and/or provide feedback on planning documents.
  - Participate in regular check-in meetings.
  - Assist in case documentation collection.
  - Contact providers as needed to obtain documentation.
  - Use SMERF to review error findings.
  - Take actions in SMERF to file DRs and Appeals.

Tracking Errors, Improper Payment Reporting, Next Steps, Contacts

Tracking Errors and Responding to Findings

- States use the SMERF system to:
  - Look up individual claims.
  - Track documentation requests (MRR, EP1, and DP P1).
  - Track ER, MR, and DP review findings.
  - Access SUD reports, year-to-date errors.
  - Request DRs and appeals for DP, MR, and ER findings.
  - Access improper payment rates and final findings.
  - Access state educational resources.
  - Add contact information to receive PERM alerts (automated email notifications).

- The RC holds SMERF system orientations for all states before records are collected, including ER, DP, and MR documentation (training planned to take place in February 2025).

Tracking Errors and Responding to Findings (cont'd)

- SMERF Functionality:
  - Claims Detail Screen: Offers details for the PERM ID including MRR letter and call log, provider information, and the status and findings of each ER, DP, and MR.
  - Policy Menu: Policies collected and displayed include federal regulation citations, state policy citations for MRs, ERs, and DP reviews.
  - Reports Menu: Includes EP1 and DP P1 reports that are updated in real time to communicate with states on information needed to complete reviews; PERM alerts will be sent from SMERF to advise states when pended reviews are past the 14-day response time; pending claims will be converted to errors if documentation is not provided timely.

Tracking Errors and Responding to Findings (cont'd 2)

- SMERF Functionality (cont'd):
  - Individualized Reports: States can select which data are needed for their reports based on available data sources by selecting fields in the drop-down menu; standard reports selectable as the default, if needed.
- Errors are officially reported to states through SUD reports on the 15th and 30th of each month.
- States receive Advance Notice of Error PERM alerts for every ER, DP, and MR error identified between SUDs. Please note that errors cited on the day prior to a SUD will not result in a advance notice of error and will first be reported on the SUD the following day.

Tracking Errors and Responding to Findings (cont'd 3)

- The state has 25 business days from the SUD report date to request DR.
  - DRs are requested via SMERF; documentation for DRs is submitted to contractors via SFTP.
  - Re-pricing of partial MR errors may be requested through the DR process (recommended for ease of tracking) but may also be requested via email after the DR time frame has closed. Reducing the error amount on claims benefits the state as well as providing a more accurate national error rate estimate.
- States have 15 business days from DR decision to appeal errors to CMS.
- States are required to return the federal share of overpayments identified on sampled FFS and MC payments.
  - Please note that sampled overpayments identified through the PERM ER are not subject to recoveries but are subject to disallowance requirements in section 1903(u) of the Social Security Act (the Act).
- States will receive a Final Errors For Recovery report that lists all claims with an overpayment error.
- States are required to develop a Corrective Action Plan (CAP) to address each error.

Improper Payment Rate Reporting

- The official Medicaid and CHIP national rolling improper rates are reported annually in the CMS AFR each November.
  - Links to CMS and HHS Financial Reports are on the SMERF home page.
- Following the posting of the AFR, each state receives its state-specific improper payment rates and findings through the Error Rate Notifications, Cycle Summary Reports, and CAP Templates.
- This release of official improper payment rates marks the beginning of the corrective action process.

Next Steps

- **May/June 2024:**
  - Complete State Contact and Information surveys by May 6, 2024.
  - FFS and managed care sample sizes sent to states by May 31, 2024.
  - Attend PERM General Education Webinar (May).
  - PERM + presentations offered (May).
  - Data submission instructions distributed to states (May).
  - Data submission instruction meetings held (May - June).
  - Communicate decision between PERM+ and routine PERM by May 31, 2024.
  - Identify requirements, technology and security training needed to provide secure, remote systems access to the RC and ERC (all states).
  - Identify all DUA/Business Associate Agreements (BAAs) that will need to be completed (state and vendors).
- **July 2024:**
  - Claims orientations/intake sessions begin (June - July).
  - Provide all necessary DUAs and system access forms (July - October).

Next Steps (cont'd)

- **August 2024:**
  - Continue claims orientation/Intake Meetings.
  - Hold CMS 64/21 Intake Meeting.
  - Continue work to obtain remote systems access for reviewers.
  - Continue to develop and finalize DUAs/BAAs with contractors.
- **September/October 2024:**
  - Hold Eligibility Intake Meetings and continue eligibility system access discussions.
  - Review Eligibility Policy Survey (September).
  - Assist in the collection on non-publicly available state policies.
  - Alert Lewin no later than September 15, 2024, if DUA/other data agreement is needed for data submission.
  - Prepare for universe data submission (September/October).
  - Quarter 1 claims data due October 15.
  - DP and MR/MRR questionnaires sent to states for completion (October/November).
  - Fully execute all DUAs/BAAs with ERC and RC before October 31, 2024.

Next Steps (cont'd 2)

- **November 2024 – February 2025:**
  - Details Intake Meetings begin February for routine PERM states.
  - Ensure RC and ERC have remote systems access in place.
  - Participate in DP, SMERF, and MR/MRR Orientation meetings (December - March).
  - Finalize MPL with the RC (January - February).
  - Review and approve the *Eligibility Case Review Planning* document.

Communication, Collaboration, and Additional Resources

- **RY 2026 PERM Cycle 2 Calls:**
  - The cycle calls will occur on the third Thursday of each month from 2-3:00 p.m. Eastern Time.
  - First cycle call will be held in June or July.
- **CMS PERM Website:**
  - PERM Manual.
- **SMERF>Tools>State Educational Resources:**
  - SMERF Overview, SMERF User Guide, multiple SC, ERC, and RC fast fact sheets on ER, MR, and DP review topics, processes, accessing SUD reports, filing DRs and appeals, suppressing MR for providers under fraud investigation, and ERC and RC SFTP access, etc.

PERM State Liaison Contact Information

Cycle 2 States	CMS PERM State Liaison
Alabama, New Hampshire	Anita Moore; Anita.Moore@cms.hhs.gov
California, Vermont	Dan Weimer; Daniel.Weimer@cms.hhs.gov
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SC Contact Information

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All PERM correspondence should be directed to our central PERM inbox

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RC Contact Information

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Thank
You!