



Payment Error Rate Measurement (PERM) Manual

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I. References

A. Glossary

Account Transfer (AT) file: The electronic file of applications transferred to the state's Medicaid or Children's Health Insurance Program (CHIP) agency from the Federally-Facilitated Exchange (FFE) that contains individuals either determined or assessed by the FFE to be eligible for the state's Medicaid program or CHIP.

Active fraud investigation: A beneficiary or a provider that a state has referred to the state Medicaid Fraud Control Unit (MFCU) or similar federal or state investigative entity (including a federal oversight agency) and the unit is currently actively pursuing an investigation to determine whether the beneficiary or the provider committed health care fraud. This definition applies to both claims and eligibility.

Adjudicated claim: A claim which the state's processing system has accepted and reviewed, and the state has made a final decision to pay or to deny the claim. Therefore, an adjudicated claim can be either a paid claim or a denied claim.

Adjustment: An adjustment refers to a change to a previously processed/submitted claim. An adjusted claim can be linked to the original claim.

Administrative Services Only: An arrangement in which an organization funds its own health insurance program but hires an outside firm to perform specific administrative services. For example, the Medicaid program/CHIP may contract an insurance company or other administrator to evaluate and process claims for the program while retaining the responsibility to pay the claim.

Aged, Blind, and Disabled (ABD): Medicaid eligibility category for adults 65 and older or anyone who is blind and/or disabled, as defined by the Social Security Act (the Act).

Agency Financial Report (AFR): This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to the federal government. The report is prepared in accordance with the requirements of the Office of Management and Budget (OMB) Circular A-136, Financial Reporting Requirements.

Beneficiary: A recipient of Medicaid program or CHIP benefits.

Capitation: A previously determined (fixed) payment, usually made on a monthly basis, for each beneficiary enrolled in a Managed Care (MC) plan or for each beneficiary eligible for a specific service or set of services.

Case: A beneficiary's eligibility and enrollment record that includes all of the information used in making the relevant Medicaid or CHIP eligibility determination. A case is initially identified for PERM through an individual Fee-For-Service (FFS) or MC payment.

Case Review: The review of the eligibility determination conducted on the beneficiary that received the service for the sampled payment.

Case Review Planning Document: A state-specific document created prior to the PERM cycle that provides background information to support the Eligibility Review Contractor (ERC) in conducting each state’s PERM eligibility reviews.

Caseworker Action: Any interaction with a beneficiary’s case by a caseworker, including but not limited to processing applications or redeterminations, processing changes to applications or redeterminations, and verifying applicant information and is not action automatically completed by the system.

CHIP: A program that provides health coverage to eligible children through both Medicaid and separate CHIP. CHIP is administered by states, according to federal requirements ([42 Code of Federal Regulations \(CFR\) § 457](#)). The program is funded jointly by states and the federal government and is authorized under Title XXI of the Act.

CHIP universe (FFS Claims/MC Capitation Payments): Claims for services paid with Title XXI funds, including Title XXI Medicaid expansion claims and payments (where beneficiaries are Medicaid enrollees, but their claims and payments are matched with Title XXI funding) that are funded under CHIP.

Claim: A request for payment, on either an approved form or electronic media, for services rendered generally relating to the care and treatment of a disease or injury or for preventative care. A claim may consist of one or several line items or services.

Code of Federal Regulations (CFR): The CFR annual edition is the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the federal government produced by the Office of the Federal Register and the Government Publishing Office.

Copay: A payment a beneficiary makes for a service in addition to what the Medicaid program or CHIP reimburses providers for the service.

Corrective Action Plan (CAP): Following each measurement cycle, each state included in the measurement is required to complete and submit a CAP based on the errors found during the PERM process. The CAP process involves analyzing findings from the PERM measurement, identifying root causes of errors, and developing corrective actions designed to reduce major error causes, trends in errors, or other vulnerabilities for purposes of reducing improper payments. The PERM corrective action process is administered and supported by the Center for Program Integrity (CPI), through the Division of State Partnership (DSP).

Cycle: The 17 or 18 state/district/territory¹ three-year rotation used to measure improper payments. The cycle including Puerto Rico consists of 18 states (16 states, the district, and the territory). The other two consist of 17 states.

Cycle cutoff date: This is the last date of the PERM cycle the Review Contractor (RC), and ERC will accept information from the states/providers.

¹ Hereinafter referred to as “state.”

Cycle improper payment rate: The combined improper payment rate for the states measured in the current cycle. This may also refer to the component rates for the cycle where specified.

Cycle Summary Report (CSR): CSRs provide official notification of cycle findings and improper payment rates. Centers for Medicare and Medicaid Services (CMS) typically releases these reports around mid-November of the Reporting Year (RY) under review. Each state receives two reports—one for Medicaid and the other for CHIP. CSRs contain detailed data analysis of the state’s Medicaid and CHIP error findings. States can also use these reports to analyze the PERM cycle results for each component more closely or as the basis for their approach to CAPs.

Data Processing (DP) review: Reviews conducted on each sampled FFS and MC payment to validate the state correctly processed the claim or payment based on information found in the state’s claim processing system and other supporting documentation the state maintains.

Denial: An action taken on an application when an individual is determined not eligible to receive Medicaid or CHIP coverage based on categorical, financial, non-financial, or medical requirements.

Denied claim or line item: A denied claim or line item is one where the claim processing system has accepted and reviewed and the state has made a final decision not to pay the claim or line item in whole or in part.

Determination: The action the state took using eligibility criteria to evaluate if an applicant was eligible to receive Medicaid and/or CHIP coverage, either through a new application, a renewal, or based on a change in circumstances.

Difference resolution (DR): A process that allows states to dispute the RC’s and/or ERC’s error findings.

Eligibility: Meeting the state’s categorical and financial criteria for receiving benefits under the Medicaid program or CHIP.

Eligibility Criteria: The categorical, financial, non-financial, and medical requirements used to evaluate whether an individual is eligible to receive Medicaid or CHIP coverage.

Eligibility system: An electronic database that houses beneficiary data and processes eligibility determinations.

Encounter data: Encounter data or “shadow claims” are informational-only records providers or managed care organizations (MCOs) submit to a state for services covered under a MC capitation payment. A state often collects this data to track utilization, assess access to care, and possibly to compute risk adjustment factors for at-risk MC contractors. Encounter data are not claims submitted for payments.

ERC: The federal contractor responsible for conducting PERM eligibility case reviews on a sample of the state’s MC capitation payments and FFS claim payments to determine the appropriateness of the state’s eligibility determination.

Error Rate Notification: A letter from CMS that provides the states with official notification of their state-specific improper payment rate results. Each state receives two such notifications—one for Medicaid and the other for CHIP. The notifications give the state’s improper payment rates for FFS, MC, eligibility, and overall, along with the sample size for each of these components. Along with the current cycle’s results, the notifications also disclose the state’s projected sample sizes and target improper payment rates for its next PERM cycle.

Express Lane Eligibility (ELE): A process that permits a state to rely on information from an Express Lane Agency outside of the Medicaid and CHIP agency(ies) to determine whether an individual satisfied one or more factors of eligibility for Medicaid or CHIP. Express Lane Agencies may include Supplemental Nutrition Assistance Program (SNAP), School Lunch, Temporary Assistance for Needy Families, Head Start, National School Lunch Program, and Women, Infants, and Children, among others. Cases determined through ELE are not subject to PERM review and any sampled claims associated with such cases are dropped from the PERM sample.

Federal Financial Participation (FFP): The Federal Government's share of the state's expenditures under the Medicaid program and CHIP.

Federal Medical Assistance Percentage (FMAP): The specified percentage of state program expenditures paid to states by the federal government. In the PERM review, FMAP is specified at the claim level.

Federal Register: The Federal Register contains rules and regulations which are regulatory documents having general applicability and legal effect. Most rules are codified in the CFR.

Federal Tax Information (FTI): Information contained on an individual’s federal tax return.

FFE: The health insurance exchange established by the Federal Government with responsibilities that include making Medicaid and CHIP determinations for states that delegate authority to the FFE.

FFE Assessment (FFE-A): Cases assessed by the FFE in states that have not delegated the authority to make Medicaid/CHIP eligibility determinations to the FFE and where the applicant's account is transferred to the state for the final eligibility determination.

FFE Determination (FFE-D): Cases determined by the FFE in states that have delegated the authority to make Medicaid/CHIP eligibility determinations to the FFE.

FFS: A traditional method of paying for medical services by which a state pays providers for each service rendered.

Final Errors For Recovery (FEFR) Report: Report generated at the end of the PERM cycle identifying overpayments on claims where both the DP review and medical review (MR) (when required) are complete, and all DR/Appeals timeframes have expired.

Health Insurance Premium Payment (HIPP) program: A program allowing states to choose to

have Medicaid or CHIP pay beneficiaries' private health insurance premiums when it is more cost-effective than paying for the full cost of Medicaid or CHIP services.

Improper payment: An improper payment is defined by the Payment Integrity Information Act (PIIA) of 2019 as “Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts are overpayments and underpayments (including inappropriate denials of payment or service). An improper payment includes any payment that was made to an ineligible beneficiary or for an ineligible service, duplicate payments, payments for services not received, and payments that are for the incorrect amount. In addition, when an agency’s review is unable to discern whether payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an error.”

Improper payment rate: An annual estimate of improper payments made under Medicaid and CHIP equal to the projected improper payments from the sample divided by the total paid amounts. Projected improper payments include both overpayments and underpayments expressed as an absolute value.

Improper Payments Elimination and Recovery Act (IPERA): Legislation from 2010 amending IPIA, which reaffirmed necessity of the PERM measurement and required additional “supplemental” measures for vulnerable programs.

Improper Payments Elimination and Recovery Improvement Act (IPERIA): Legislation from 2012 amending IPERA, which adds responsibilities to the Office of Management and Budget (OMB), federal agencies, and their inspector generals in order to better manage payment practices and reduce the incidence of improper payments.

Improper Payments Information Act (IPIA): Legislation from 2002 requiring reviews of high spending federal programs for improper payments that identified Medicaid and CHIP as susceptible programs.

Individual reinsurance: In the context of PERM MC universe files, individual re-insurance payments are those payments made by the state to an MC plan for an individual beneficiary whose cost of care has exceeded a predetermined maximum amount, usually measured on an annual basis or based on a specific episode of care. Such payment by the state typically represents a cost-sharing arrangement with an MC plan for extremely high-cost enrollees. Individual reinsurance may be based on the costs associated with all services the MC plan provides or may be limited to excessive costs associated with certain services (e.g., transplants). (Note: The PERM program considers providers whose payment rates are fully reconciled for actual costs incurred, on a retrospective basis, FFS.)

Ineligible: Based on categorical, financial, non-financial, and medical requirements, an individual should not be receiving Medicaid or CHIP coverage.

Ineligible Services: Based on the eligibility aid category to which the beneficiary is assigned, she/he was not eligible to have specific services that were paid for by the Medicaid or CHIP agency.

Kick payment: Supplemental payment over and above the capitation payment made to MC plans for beneficiaries utilizing a specified set of services or having a certain condition.

Line item: An individually priced service presented on a claim for payment.

MC: A system where the state contracts with health plans, on a prospective full-risk or partial-risk basis, to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered.

MCO: An entity that has entered into a risk contract, with a state Medicaid and/or CHIP agency, to provide a specified package of benefits to Medicaid and/or CHIP beneficiaries. The MCO assumes financial responsibility for services delivered and is responsible for contracting with and reimbursing servicing providers. State payments to MCOs typically are a monthly capitation payment per enrolled beneficiary.

Medicaid: A program that provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements ([42 CFR § 431](#)). The program is funded jointly by states and the federal government under Title XIX of the Act.

Medicaid Eligibility Quality Control (MEQC): Program that focuses on reducing improper eligibility determinations by performing extensive reviews on a sample of cases to determine whether individuals were correctly determined for Medicaid and CHIP eligibility in a specific sample month.

Medicaid universe (FFS Claims/MC Capitation Payments): Claims for all services paid with Title XIX funds.

Medicare: The federal health insurance program for people 65 years of age or older and certain younger people with disabilities or end stage renal disease.

Modified Adjusted Gross Income (MAGI): A calculation of income used to determine an individual's eligibility for insurance affordability programs. Income eligibility for these programs is based on an individual's MAGI income in relation to the federal poverty level. MAGI is adjusted gross income (using the tax definition) plus foreign earned income excluded from taxes, non-taxable Social Security benefits (except for Supplemental Security Income [SSI], which is not counted) and tax-exempt interest. In general, eligibility for Medicaid and CHIP is based on current monthly household MAGI. Also, some Medicaid eligibility is not based on MAGI.

Modified Adjusted Gross Income (MAGI) Verification Plan or "Verification Plan": A plan required by CMS describing the policies and procedures for verifying MAGI-based eligibility criteria that were adopted by the Medicaid and CHIP agency(ies).

Monetary Loss: Monetary loss occurs when payments are made to the wrong recipient and/or in the wrong amount.

MR error: An error that is determined from a review of the medical documentation in conjunction

with federal regulations, state medical policies, and information presented on the claim.

Non-MAGI: Eligibility categories with financial criteria that do not adhere to the MAGI rules, including ABD groups.

Observation: An identified instance of non-compliance with federal regulation or state policy during a case review that does not result in a difference between the amount that was paid and the amount that should have been paid (i.e., an improper payment).

OMB: OMB oversees the performance of federal agencies and administers the federal budget.

Overpayment: Overpayments occur when Medicaid or CHIP pays more than the amount the provider was entitled to receive or more than the claim's federal share of the cost based on existing policies and contracts.

Paid claim: A claim or line item for which the claims processing or payment system accepted, adjudicated, determined to be a covered service, and issued a payment. A claim where no payment was owed, due to circumstances such as a payment made by a third-party insurer, is also considered a paid claim.

Partial error: Partial errors are those that affect only a portion of the payment on a claim.

Payment: Any payment to a provider, insurer, or MCO for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP FFP.

PERM website: The official CMS website for the PERM program, located at <http://www.cms.gov/PERM>.

PERM+: A claims and payment data submission method through which the state submits claims, provider, and beneficiary data to the Statistical Contractor (SC). The SC uses the data to build sampling universes from which it selects a sample of claims. After selecting the samples, the SC sends the samples to the RC, the ERC, and the states. The SC then populates the sampled FFS claims with detailed service, payment, provider, and beneficiary information and sends these samples to the RC to facilitate the RC requesting medical records.

PIIA: Legislation from 2019 requiring federal agency leaders to assess and identify high-risk or otherwise significant programs and activities and share these findings in an annual publication.

Premium: Cost-sharing amount that a beneficiary is responsible for paying for enrollment in Medicaid or CHIP. Premiums can be required up front, on a monthly or annual basis, or both.

Prepaid Ambulatory Health Plan (PAHP): A benefit that states may choose to offer enrollees on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates; does not provide or arrange and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

Prepaid Inpatient Health Plan (PIHP): A benefit that states may choose to offer enrollees on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates; provides, arranges, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

Primary Care Case Management (PCCM): A program that links beneficiaries to a primary care provider who coordinates their health care. Providers receive small additional payments to compensate for care management responsibilities, typically on a Per-Member-Per-Month basis. Providers are not at financial risk for the services they provide or authorize.

Program of All-inclusive Care for the Elderly (PACE): An interdisciplinary team of health professionals who provide elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits, with coordinated care including comprehensive medical and social services in a community-based setting rather than receiving care in a nursing home.

Redetermination: A re-assessment of eligibility made after the initial determination. Redetermination occurs annually and after an update to an account or application.

Renewal: The annual process required to confirm an enrolled individual's continued eligibility for Medicaid or CHIP.

Retirement, Survivors, and Disability Insurance (RSDI): A federal income benefit paid to those who no longer work and their family members. RSDI payments are administered through the Social Security Administration (SSA) and include retirement benefits, disability insurance and dependent, and survivors' benefits. To be eligible for any RSDI payments, an individual must have worked for a certain number of years, paying FICA taxes into the Social Security system.

RC: The federal contractor responsible for conducting PERM medical and DP reviews on a sample of the state's managed care and FFS claim payments as well as hosting and maintaining the SMERF system.

Risk-Based Screening (RBS): [42 CFR § 455.436\(b\)](#) lists the federal database checks that must be performed as a component of the enrollment process for all providers. [42 CFR § 424.518](#) explains the limited, moderate, and high risk screening levels for Medicare providers and suppliers. [42 CFR § 455.410](#) requires state Medicaid agencies (SMAs) to screen participating providers according to the categorical or elevated risk of fraud, waste, or abuse they pose to the Medicaid program. This regulation also states the SMA may rely on the results of the provider screening performed by Medicare or its contractors and Medicaid and CHIP agencies of other states. [42 CFR § 455.450](#) describes screening that the SMA must perform based on the categorical risk levels of limited, moderate, and high. The RBS DP review determines if the state has properly performed and documented all screening elements.

Rolling rate: The official Medicaid program and CHIP improper payment rates that include findings from the most recent three cycles to reflect findings from all 52 states.

Routine PERM: A claims and payment data submission method through which the state submits

claims universes to the SC. The SC draws a random sample of claims from the quarterly universes the state submits. After drawing the samples, the SC sends the RC and ERC the samples. The SC also sends the states a list of their sampled claims, and states populate sampled FFS claims with detailed service and payment information for the SC. The SC formats the state submissions and sends them to the RC to facilitate the RC requesting medical records.

Sample: The randomly selected FFS claims and managed care payments selected from quarterly Medicaid and CHIP universes that will have data processing, medical records (FFS only), and eligibility reviewed.

Sampling unit: The payment that is sampled from the universe for review. The beneficiary associated with the sampled payment will be reviewed for eligibility.

Sampling Unit Disposition (SUD) reports: The formal DR period will not begin until the completed findings for a case are published to the states in the SUD report on the 15th and the 30th day of the month.

Self-Attestation: The policy that allows beneficiaries to indicate that they meet certain, state-selected eligibility criteria without providing verification documentation. This may also be referred to as self-declaration.

SSA: An independent agency of the Federal Government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' benefits. SSA provides information to the Exchanges through the Federal Data Services Hub (FDSH) to support the validation of Social Security Numbers (SSNs) and the verification of citizenship, income from Social Security benefits (except for Supplemental Security Income [SSI], which is not counted), incarceration status, and quarters of coverage. SSA also makes Medicaid eligibility determinations for 1634 states.

State Medicaid Error Rate Findings (SMERF) system: A web-based application used to track and report sampling unit review findings for the PERM program.

State Plan: A contract between a state and CMS describing how that state administers its Medicaid program or CHIP.

State Plan Amendment (SPA): When a state is planning to make a change to its program policies or operational approach, states send SPAs to the CMS for review and approval to amend their state plans. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information.

State-Only Funded: Eligibility categories that do not receive any federal matching funds.

SC: The organization that conducts the statistical sampling, calculation, analysis, and reporting of state and national improper payment rates. The SC builds the universe of data with the state, samples the data, and sends the sample to the ERC and RC. At the end of the cycle, the ERC and RC send their findings to the SC for calculations.

SNAP: The federal program offering nutrition assistance to eligible low-income individuals and families.

Stop-loss: See “Individual Reinsurance,” above.

SSI: A federal income supplement program designed to help aged, blind, and disabled people who have little or no income and no or limited work history, which provides cash assistance to meet basic needs for food, clothing, and shelter. SSI payments are administered through the SSA.

Supplemental payments for specific services or events: Often called “kick” payments, these are payments a state may make to an MCO on behalf of a particular enrollee in the MC plan based on the provision of a particular service or the occurrence of a particular event, such as childbirth.

Technically improper payment: A non-monetary loss type of improper payment made to an otherwise qualified recipient for the right amount, but the payment failed to meet all regulatory and/or statutory requirements. Technically improper payment errors will not be included in each state’s FEFR report and will not be required to be recovered.

Temporary Assistance for Needy Families: The program that provides temporary financial assistance for pregnant women and families with one or more dependent children.

Termination: The action when coverage ends for a beneficiary because s/he was determined to be ineligible for coverage under Medicaid or CHIP. Some states also use the term “cancellation” in reference to this process.

The Act: The Act was signed into law in 1935 with limited provisions for general welfare and created a social insurance program designed to pay retired workers age 65 or older a continuing income after retirement. The Act has been amended several times since it was signed into law in 1935 to add new benefits and expand current benefits and programs. The Medicare and Medicaid Act of 1965, also known as the Social Security Amendments of 1965, established Medicare, a health insurance program for the elderly, and Medicaid, a health insurance program for people with limited income. Title XIX of the Act provides for the federal Medicaid program. The Balanced Budget Act of 1997 created a new children’s health insurance program under Title XXI of the Act. This new Title enabled states to initiate and expand health insurance coverage for uninsured children.

Third-Party Data Source: Data that is available through existing national and state databases, which can be utilized to verify beneficiary information.

Third-Party Liability (TPL): Refers to third parties who have a legal obligation to pay for part or all the cost of medical services provided to a Medicaid beneficiary. Examples are other programs such as Medicare, or other health insurance the individual may have that covers at least some of the cost of the medical service. If a third party has such an obligation, Medicaid will only pay for the remaining portion.

Title IV-E (Foster Care): A program authorized by Title IV-E of the Act, as amended, and

implemented at [45 CFR § 1355](#), [45 CFR § 1356](#), and [45 CFR § 1357](#) that provides out-of-home funding for care of children placed in foster care. Not all foster care children qualify for Title IV-E payments, which is a separate determination than Medicaid eligibility.

Title XIX (Medicaid): A program authorized by Title XIX of the Act, as amended, and implemented under 42 CFR that provides health coverage to individuals and families with resource needs.

Title XXI (CHIP): A program authorized by Title XXI of the Act, as amended, and implemented under 42 CFR that provides health coverage to children with resource needs.

Underpayment: Underpayments occur when the state pays less than the amount the provider was entitled to receive or less than its share of cost.

Universe (Claims): The term used to refer to all payments for a particular Medicaid program or CHIP from which the sample is selected. The sample is used to calculate and project the improper payment rate for the entire group of payments (universe).

Zero-paid claim: A zero-paid claim or line is one where the claims processing or payment system has accepted, adjudicated, and approved for payment, but for which the actual amount remitted was zero dollars. This can occur due to TPL, application of deductibles and patient liability, or other causes.

B. Acronym Dictionary

Acronym	Definition
ABD	Aged, Blind, and Disabled
AFR	Agency Financial Report
AT	Account Transfer
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
CPT	Current Procedural Terminology
CSR	Cycle Summary Report
DFO	Division of Financial Operations
DME	Durable Medical Equipment
DOS	Date Of Service
DP	Data Processing
DR	Difference Resolution
DRG	Diagnosis-Related Group
ELE	Express Lane Eligibility
ePHI	electronic Protected Health Information
ERC	Eligibility Review Contractor
esMD	electronic submission of Medical Documentation
FDSH	Federal Data Services Hub
FEFR	Final Errors for Recovery
FEMA	Federal Emergency Management Agency
FFE	Federally-Facilitated Exchange
FFE-A	Federally-Facilitated Exchange Assessment
FFE-D	Federally-Facilitated Exchange Determination
FFP	Federal Financial Participation
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Centers
FR	Federal Register
FTI	Federal Tax Information
FY	Fiscal Year
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPP	Health Insurance Premium Payment
ICD	International Classification of Diseases
ICF	Intermediate Care Facility

Acronym	Definition
IHS	Indian Health Services
IPERA	Improper Payments Elimination and Recovery Act
IPERIA	Improper Payments Elimination and Recovery Improvement Act of 2012
IPIA	Improper Payments Information Act of 2002
IRS	Internal Revenue Service
MAGI	Modified Adjusted Gross Income
MC	Managed Care
MCO	Managed Care Organization
MEQC	Medicaid Eligibility Quality Control
MMIS	Medicaid Management Information System
MPL	Master Policy List
MR	Medical Review
MRR	Medical Record Request
MSP	Medicare Secondary Payer
NEMT	Non-Emergency Medical Transportation
OCR	Office for Civil Rights
OIG	Office of the Inspector General
OMB	Office of Management and Budget
PACE	Program of All-inclusive Care for the Elderly
PAHP	Prepaid Ambulatory Health Plan
PAM	Payment Accuracy Measurement
PCCM	Primary Care Case Management
PERM	Payment Error Rate Measurement
PHI	Protected Health Information
PIIA	Payment Integrity Information Act of 2019
PIHP	Prepaid Inpatient Health Plan
PII	Personally Identifiable Information
POC	Point of Contact
RC	Review Contractor
RHC	Rural Health Center
RSDI	Retirement, Survivors, and Disability Insurance
RY	Reporting Year
SC	Statistical Contractor
SMERF	State Medicaid Error Rate Findings
SNAP	Supplemental Nutrition Assistance Program
SPA	State Plan Amendment
SSA	Social Security Administration
SSI	Supplemental Security Income
SUD	Sampling Unit Disposition
TPL	Third-Party Liability
USPS	United States Postal Service

II. PERM Program Introduction

A. Overview of the PERM Program

The purpose of the PERM program is to measure and report a national improper payment rate for Medicaid and the Children’s Health Insurance Program (CHIP) to comply with the requirements of PIIA. CMS uses a 17- or 18-state rotation per cycle, reviewing each state every three years. The PERM SC selects a stratified random sample of payments from each state’s universe of payments for one reporting year. The PERM RC reviews all claims sampled to determine if each state’s payment decisions complied with applicable federal regulations and state policies. The PERM ERC reviews the eligibility determination made for eligibility claims to determine whether the state’s decisions complied with applicable federal regulations and state policies.

B. PERM Legislative Background

IPIA, Pub. L. 107–300, enacted on November 26, 2002, required the heads of federal agencies annually to review programs they oversee that are susceptible to significant erroneous payments. The IPIA directed OMB to provide guidance on implementation. OMB defined “significant erroneous payments” as annual erroneous payments in the program exceeding both 2.5% of program payments and \$10 million (OMB M–03–13, May 21, 2003, and OMB M–06–23, August 10, 2006).

According to the OMB directive, federal agencies must report to the President and Congress: (1) the estimate of the annual amount of erroneous payments; (2) the causes of the errors and actions taken to correct them, including plans to increase agency accountability; (3) the amount of actual erroneous payments the agency expects to recover; (4) limitations that prevent the agency from reducing the erroneous payment levels (for example, resources or legal barriers); and (5) a target for the program’s future payment rate, if applicable.

OMB identified the Medicaid program and CHIP as at risk for significant erroneous payments. OMB directed HHS to report the estimated improper payment rates for the Medicaid program and CHIP each year for inclusion in the AFR. Through the Payment Accuracy Measurement (PAM) and PERM pilot projects that CMS operated in Fiscal Year (FY) 2002 through 2005, CMS developed a claims-based review methodology designed to estimate state-specific improper payment rates for all adjudicated claims within three percent of the true population improper payment rate with 95% confidence.

IPERA, Pub. L. 111-204, amended the IPIA on July 10, 2010. IPERA required agencies to conduct annual risk assessments, and if an agency found a program to be susceptible to significant improper payments, the agency was required to measure improper payments in that program.

On January 10, 2013, IPERIA, Pub. L. 112-248, further amended IPERA. The aim of IPERIA

was to emphasize the importance of not only identifying and recovering improper payments but also to conduct the necessary analyses to reduce improper payments.

On March 2, 2020, PIIA of 2019, Pub. L. 116-117, replaced IPIA, IPERA, and IPERIA and incorporated key elements to maintain an improper payment measurement.

C. CMS Rulemaking

[Section 1102\(a\)](#) of the Act authorizes the Secretary of HHS to establish rules and regulations necessary for the efficient administration of the functions of the Medicaid program and CHIP. The Medicaid statute at section [1902\(a\)\(6\)](#) of the Act and the CHIP statute at section [2107\(b\)\(1\)](#) of the Act require states to provide information the Secretary finds necessary for the administration, evaluation, and verification of the states' programs. In addition, section [1902\(a\)\(27\)](#) of the Act and codified by CMS at [42 CFR § 457.950](#) requires providers to submit information regarding payments and claims as the Secretary, state agency, or both request that information.

Under the authority of these statutory provisions, CMS published a proposed rule on August 27, 2004 ([69 FR 52620](#)) to comply with the requirements of the IPIA and the OMB guidance. Based on the methodology developed in the PAM and PERM pilot projects, the proposed rule set forth provisions for all states annually to estimate improper payments in their Medicaid program and CHIP and to report the state-specific improper payment rates for purposes of computing the national improper payment estimates for these programs. The intended effects of the proposed rule were to have states measure improper payments based on FFS, MC, and eligibility reviews; to identify errors; to target corrective actions; to reduce the rate of improper payments; and to produce a corresponding increase in program savings at both the state and federal levels.

After extensive analysis of the issues related to having states measure improper payments in Medicaid and CHIP, including a review of public comments on the provisions in the proposed rule, CMS revised its approach. CMS adopted the recommendation to engage federal contractors to review state Medicaid and CHIP FFS and MC claims, and to calculate the state-specific and national improper payment rates for Medicaid and CHIP. CMS also adopted the recommendation to sample a subset of states each year rather than to measure every state every year. CMS implemented these recommendations primarily in response to commenters' concerns with the cost and burden the proposed rule would have imposed on states to implement the regulatory provisions at the state level.

Since CMS's revised approach departed significantly from the one described in the proposed rule, CMS published an interim final rule with comment period on October 5, 2005 ([70 FR 58260](#)). The October 5, 2005, interim final rule with comment period responded to the public comments on the proposed rule and informed the public of the national contracting strategy and of the plan to measure improper payments in a subset of states. The PERM program will measure a state once, and only once, every three years for each program. For each FY, CMS stated that it expected to measure up to 18 states.

In the October 5, 2005, interim final rule, CMS stated that states sampled for review may still be required to conduct eligibility reviews as described in the proposed rule.

CMS also announced its intentions to establish an eligibility workgroup to make recommendations on the best approach for reviewing Medicaid and CHIP eligibility within the confines of current statute, with minimal impact on states and additional discretionary funding. CMS convened an eligibility workgroup comprised of HHS (including CMS and, in an advisory capacity, the Office of the Inspector General [OIG]), OMB, and representatives from two states. CMS determined that states should conduct the eligibility measurement and developed an eligibility measurement methodology based on the workgroup's consideration of public comments, the examination of various approaches proposed in such comments, and the suggestions of the panel members. The October 5, 2005, interim final rule also set forth the types of information that states would submit to the federal contractors for the purpose of estimating Medicaid and CHIP FFS improper payments and invited further comments on methods for estimating eligibility and MC improper payments. CMS received very few comments regarding MC and a number of comments regarding eligibility.

Based on the public comments and recommendations from the eligibility workgroup, CMS published a second interim final rule on August 28, 2006 ([71 FR 51050](#)), which established the methodology for measuring improper payments in Medicaid and CHIP FFS, MC, and eligibility in 17 states per cycle² and invited further public comments on the eligibility measurement. CMS implemented the PERM program in a final rule published on August 31, 2007 ([72 FR 50490](#)). The August 31, 2007, final rule responded to the public comments on the August 28, 2006, interim final rule and finalized state requirements for submitting claims to the federal contractors that conduct FFS and MC reviews. The final rule also finalized state requirements for conducting eligibility reviews and estimating improper payment rates due to errors in eligibility determinations.

On February 4, 2009, the federal government enacted [CHIPRA \(Pub. L. 111-3\)](#). Sections 203 and 601 of CHIPRA relate to the PERM and MEQC programs. Section 203 of CHIPRA established an improper payment rate measurement with respect to the enrollment of children under the ELE option. The law directed states not to include children enrolled using the ELE option in data or samples used for purposes of complying with the MEQC and PERM requirements.

Section 601(a) of CHIPRA provided for a 90% federal match for CHIP expenditures related to PERM administration and excluded such expenditures from the 10 percent administrative cap. (Section 2105(c)(2) of the CHIP statute gives states the ability to use an amount up to 10% of the CHIP benefit expenditures for outreach efforts, additional services other than the standard benefit package for low-income children, and administrative costs.) CHIPRA required a new PERM rule and delayed any calculation of a PERM improper payment rate for CHIP until six months after the new PERM rule was effective. CHIPRA required that the new PERM rule include:

² This final rule specifies that 17 states would be selected for review per cycle, which is a change from prior guidance that reflected either "17 or 18" or "up to 18" states per cycle.

- Clearly defined criteria for errors for both states and providers.
- Clearly defined processes for appealing error determinations.
- Clearly defined responsibilities and deadlines for states in implementing any CAPs.
- A provision that the improper payment rate for a state will not include payment errors based on a state's verification of an applicant's self-attestation if a state's self-attestation verification policies meet regulations promulgated by the Secretary or are approved by the Secretary.
- State-specific sample sizes for application of the PERM requirements to CHIP.

In addition, CHIPRA aimed to harmonize the PERM and MEQC programs and provide states with the option to apply PERM data from eligibility reviews to meet MEQC requirements and vice versa, with certain conditions.

As required by CHIPRA, CMS proposed revised MEQC and PERM provisions in the proposed rule published in the July 15, 2009, Federal Register ([74 FR 34468](#)). CMS implemented a revised program through a final PERM rule published on August 11, 2010 ([75 FR 48816](#)). In addition to the provisions required by CHIPRA, the final PERM rule (75 FR 48816) addressed: the claims universe, sampling, and review; the eligibility universe, sampling, and review; error determination and rate calculation; DR and appeals; and the corrective action process.

In 2010, the federal government enacted significant changes to the Medicaid program and CHIP and these changes directly affected the PERM program. As a result of this implementation, the DP review process expanded to ensure state compliance with new provider enrollment and RBS requirements. The RC reviews provider information to verify billing, ordering, and referring, and some rendering providers are screened and enrolled under [42 CFR § 455 subpart E](#).

In light of the changes to the way states adjudicate eligibility for applicants for Medicaid and CHIP required by law, the [State Health Official \(SHO\) letter 13-005](#) issued on August 15, 2013, directed states to implement Medicaid and CHIP Eligibility Review Pilots in place of PERM and MEQC eligibility review requirements.

On July 5, 2017, CMS published a final rule in the Federal Register ([82 FR 31158](#)) that implemented changes to the PERM program and implemented various other improvements to both the PERM and MEQC programs.

Prior to the publication of the final rule, CMS was not conducting the eligibility measurement component of the PERM program while it updated the eligibility component measurement methodology and related PERM program regulations. However, as of the effective date of the final rule, the eligibility measurement component resumed.

D. PERM Partners and Their Responsibilities

CMS contracts with three separate vendors to conduct the measurement of the FFS and MC components of PERM and the improper payment rate calculation: an SC, an RC, and an ERC.

SC

The SC has the following primary responsibilities: conducting Intake Meetings with the states prior to each cycle; collecting quarterly claims and capitation payment universe data; conducting quality review of the submitted data; selecting quarterly samples from the universes; calculating improper payment rates; and creating error analysis reports to assist in states' corrective actions.

Conducting Intake Meetings with States

The SC conducts an Intake Meeting with state policy, system, technical, and financial staff prior to the start of each PERM cycle. The SC and the state discuss:

- The specifications and principles guiding the PERM universe.
- Guidance from the state to build the FFS and MC universe data for submission.
- Types of payments included in and excluded from the PERM universes.
- Data sources and documentation.
- The overall PERM process with an emphasis on data quality review.

The second component of this meeting involves the SC collecting relevant information about the state's Medicaid program and CHIP, data systems, and FFS and MC payment methodologies, including nuances of the state's data and programs. The Intake Meeting serves as a forum for the states to ask the SC questions. Furthermore, the detailed discussions between the states and the SC help in shaping the state's PERM data submissions. The SC also holds separate, shorter Intake Meetings with the data and CMS-64/21 financial staff.

Collecting Quarterly Claims and Capitation Payment Data

The SC collects Medicaid and CHIP FFS and MC universe data from the states each quarter throughout the PERM cycle. Depending on the data submission method the state, the SC, and CMS choose, the data could result in relatively clean PERM universes or raw claims and payments. The quarterly submissions are due to the SC 15 days after the end of each quarter.

Conducting Quality Review of State-submitted PERM Universes

The SC performs extensive quality review of the states' universes. The review begins with the SC comparing the received quarterly data against the state-submitted summary of total records and dollars transmitted to ensure that no data were lost during transmission. The SC performs detailed checks to ensure the data are not corrupted. If the SC identifies issues during the initial quality review, the SC contacts the state for clarification. In most cases, issues must be resolved before the SC can conduct further processing.

Once the data have cleared the first stage of review, the SC performs more in-depth quality checks. In this phase, the SC's task includes, but is not limited to, ensuring that there are no:

- Adjustments or voids.
- Payments not matched with federal dollars or not fully adjudicated.
- Unexpected or missing payment amounts.

- Payments outside of the quarter.
- Missing lines for relevant claims.
- Missing unique identifiers.
- Duplicate payments.
- CHIP beneficiaries over age 19, besides pregnant women (if applicable).
- Claim dates of service exceeding date of death (if applicable).

For PERM+ states, the SC also sets sampling units depending on state reimbursement of the claim and where TPL is accounted. The payments are then categorized into PERM universes with state guidance.

The SC also reviews trends and patterns of payments within the state and across all states to ensure that the universes are accurate and PERM-compliant. The SC further compares the total dollars reported by the states in their CMS-64/21 reports with the dollars represented in the PERM universes. The comparisons allow the SC and the states to ensure that the PERM sampling universes contain all relevant federally matched payments.

If issues and questions arise during the quality review process, the SC will contact states for more information. It is important to note that, before the SC can select samples, the PERM universes must pass all stages of quality checks. Therefore, state cooperation is extremely important.

Selecting Quarterly Samples from the FFS and MC Universes

From each quality-reviewed FFS and MC universe that the SC deems complete, compliant, and accurate for sampling, the SC selects a random sample of payments based on the sample sizes and sampling methodology. The SC will then review the selected samples to ensure the information the RC and ERC require to begin DP and eligibility reviews are present. If necessary, the SC will contact the state for additional information. Once the sample selections have passed through the initial quality control (QC), the SC will send the samples to the RC, ERC, and the state so that staff can prepare for reviews. A CMS regulation prohibits the PERM contractors from releasing the sample until 60 days have passed following the end of the quarter. Therefore, if the SC selects a sample within the 60-day timeframe, the SC will share the sample with the RC and ERC, but not with the state until the 60-day period is over.

Depending on the state's data submission method, for FFS samples, the SC requests from the state or populates the "sample details," which consist of provider, beneficiary, and detailed service information for the sampled claims. These sample details go through in-depth quality review to ensure the information necessary for the RC to conduct Medical Record Requests (MRRs) is available. Once deemed complete and correct, the sample details are standardized and formatted. The SC then sends the sample details to the RC and ERC.

Calculating State and National Improper Payment Rates

The SC calculates FFS, MC, eligibility, and overall improper payment rates for Medicaid and

CHIP on the national rolling, cycle, and state level. Along with these improper payment rates, the SC includes the total number of errors and total projected improper payments for the FFS, MC, and eligibility components and overall programs on each level. The SC also calculates the state-specific FFS, MC, and eligibility sample sizes for the next PERM cycle.

Creating Error Analysis Reports to Assist States' Corrective Actions

Based on the errors identified by the RC and ERC, the SC compiles state-specific and program-specific error analysis reports. These detailed reports include information on the errors found within the state sample, along with the types of errors and reasons for those errors. States review each sampled claim in error. States use information gained from this process to formulate CAPs.

RC

The RC has four primary responsibilities: hosting and maintaining the SMERF system, collecting federal regulations and state policies, requesting medical records, and conducting DP review and MR for sampled payments.

Hosting and Maintaining the SMERF System

The RC hosts and maintains the SMERF system, which is the single system for the state to view DP, MR, and eligibility review findings. States use SMERF to track all sampled unit workload, reviews pending information, completed reviews, and final results for all review types. SMERF provides real-time information on the status of record requests, record receipts, and review progress. Within SMERF, states also have the ability to create and/or download reports, file DR requests, and file appeals. States may request SMERF access and SMERF password resets by sending an email to SMERFaccounts@empower.ai.

Collecting Federal Regulations and State Policies

The RC collects applicable federal regulations as well as state Medicaid and CHIP policies. The federal regulations collected relate to:

- Timely filing requirements.
- Requirements for provider enrollment and RBS.
- Appropriate Level of Care (LOC) and documentation standards.

The RC researches and obtains the state Medicaid and CHIP policies it uses for the MR and DP reviews directly from states or the RC reviews publicly available information. Examples of additional documentation the RC may request include:

- Claims payment policies.
- Fee schedules/pricing manuals.
- Processing system manuals to facilitate DP reviews.

Requesting Medical Records

When the RC receives sampled claims detail data from the SC, the RC will contact the providers

of the sampled FFS claims in order to obtain copies of medical records. If the records received do not contain sufficient documentation to support the service billed, the RC will request additional documentation from the provider.

Conducting DP Review and MR

When the RC receives the sampled claims list from the SC, the RC completes DP reviews. For FFS claims, the DP review includes examining line items in each claim to validate the state processed the claim correctly. The RC also performs DP reviews on MC payments to determine if the state accurately processed the capitation payment or premium.

The RC also conducts MR on FFS claims; however, MC claims are not subject to MR because there are no specific services rendered on which to make a medical necessity determination. The RC examines the medical record to ensure there is enough documentation to support the claim's billed amount, medical necessity, and coding accuracy.

ERC

The ERC has two primary responsibilities: collecting federal regulations and state policies and conducting eligibility reviews.

Collecting Federal Regulations and State Policies

The PERM eligibility case review focuses on whether a determination, redetermination, or change was processed accurately and appropriately based on applicable federal regulations and state-specific policies. As such, the ERC must obtain copies of all the relevant federal regulations and state policies that were in effect at the time of each action under review in order to conduct the reviews.

In addition to the federal policies, which apply to all states in the PERM cycle, the ERC will also obtain information from each state's regulations, waivers, and policies. The ERC shares with the state a comprehensive summary of their findings and the state reviews and confirms that all the policies documented are accurate and up to date.

Conducting Eligibility Reviews

The ERC conducts eligibility reviews, or case reviews, for all sampled claims in the eligibility sample. The case review focuses on whether a determination—a new application or renewal—was processed accurately and appropriately based on applicable federal and/or state policies. The most recent action on a case that made the individual eligible on the sampled claim's DOS is the action under review.

State Partners

States are critical partners in the PERM process and have the following responsibilities.

- Identifying and supporting a state representative who serves as the central Point of Contact (POC) and coordinates state PERM activities and providing additional state resources to

support cycle operations.

- Participating in PERM cycle and state-specific calls.
- Providing the RC and ERC access to state systems as required to complete DP and eligibility reviews, which may include and is not limited to access to:
 - Financial systems.
 - Eligibility systems.
 - Provider enrollment or screening systems.
 - Document management systems.
- Maintaining a flow of communication between relevant state staff, state vendors, CMS, and PERM contractors to ensure PERM data and operational requirements are met timely.
- Providing all claims and payment data to the SC in the required format and conducting QC reviews prior to submission to ensure compliance with specifications, including:
 - Submitting completed Universe Data Survey and data dictionary by August 15th.
 - Ensuring state personnel best able to respond to Intake Protocol questions attend the Intake Meeting (do not substitute attendance with written responses).
 - Reviewing and commenting on Intake Notes within 14 days of receiving them from the SC.
- Confirming that all relevant policies, waivers, amendments, and regulations are available to the ERC and RC.
- Providing timely and thorough responses to any contractor questions or requests for additional documentation necessary for PERM reviews.
- Educating providers on the PERM process and assisting with medical record collection.
- Evaluating error citations on a regular basis.
- Filing DR and appeals in accordance with applicable federal regulations, with proper support, and requesting repricing when appropriate for DP, MR, and eligibility reviews.

CMS

CMS also has specified responsibilities as partners in PERM. These responsibilities include:

- Maintaining and overseeing the PERM review standards, PERM program operations, and PERM contractors to ensure that CMS meets its regulatory requirements.
- Providing guidance and technical assistance to states about the measurement process as needed.
- Ensuring the PERM cycle remains on track and working with states when challenges arise.
- Coordinating and hosting monthly calls with all cycle states.
- Reviewing and responding to any state-requested appeals of error findings.
- Ensuring the accuracy of findings throughout the cycle.
- Sharing findings with CMS partners to facilitate other CMS actions such as corrective actions or recoveries.

PERM and Other CMS Components

The CMS PERM team works closely with other components in CMS throughout the measurement, including meeting regularly with Centers for Medicaid & CHIP Services (CMCS) and CPI to ensure that reviewers have the appropriate policy information impacting PERM

reviews. PERM contractors have been monitoring CMS’s guidance regarding policies in place during the unwinding period, have worked with the appropriate policy staff within CMS to confirm a complete compilation and understanding of applicable policies, and have implemented several strategies to prepare for reviewing claims that are paid and eligibility determinations that are completed during the unwinding period. These include:

- Researching and collecting publicly available state eligibility and payment policies during the COVID-19 Public Health Emergency (PHE).
- Requesting policies maintained internally by states during the PERM intake process.
- Discussing payment and eligibility processes with states when questions are encountered during reviews.
- Researching and collecting publicly available state eligibility and payment policies for unwinding
- Collaborating with CMS policy staff on any policy interpretation questions.
- For eligibility reviews, policy-related questions are shared with CMCS, the Medicaid and CHIP policy holders.
- For DP reviews, policy-related questions are shared with the CPI Provider Enrollment Group, the policy holders of provider enrollment regulations.
- For all CAP-related topics or questions, PERM works with the Audits and Vulnerabilities Group in CPI.

States should provide any policy, guidance, or procedural documents that may not be publicly available to ensure PERM contractors have all necessary policies needed to review claims accurately.

E. PERM Cycles

CMS review periods for PERM run from July to June and are in line with each state’s FY.

CMS uses a rotational approach to review the states’ Medicaid program and CHIP so that the PERM program measures each state once every three years. At the end of each three-year cycle, the rotation repeats.

CMS calculates a rolling national improper payment rate, which combines the most current findings from the three prior measurement cycles, using information from all 52 states to produce the improper payment rate for the current RY. HHS publishes the improper payment rate for the current RY in the AFR. Each time PERM measures a cycle of states, PERM drops from the calculation the previous findings for that group of states and adds the newest findings.

Exhibit 1 shows a list of states and their assignment within the rotation cycles.

Exhibit 1: Medicaid and CHIP Measurement Cycles

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

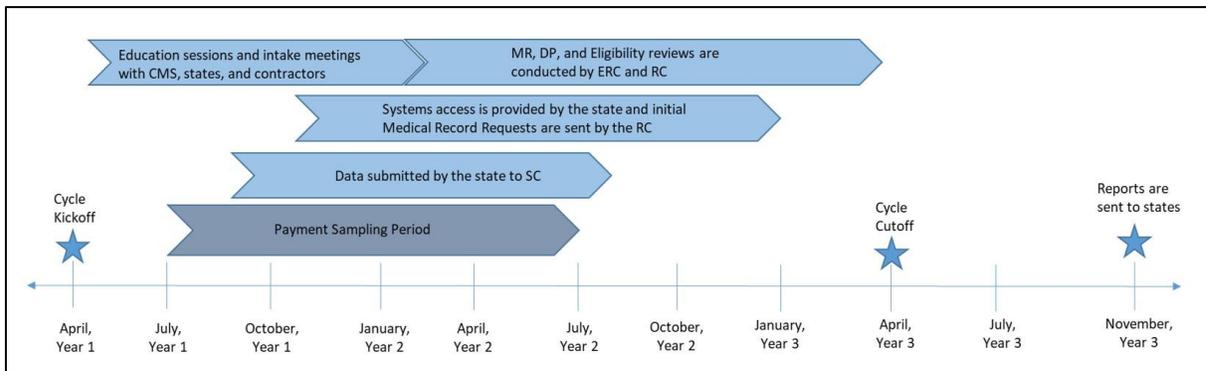
CMS assigns a PERM State Liaison from the agency to each state within each PERM cycle. The PERM State Liaison serves as the state’s main POC for that measurement, ensures the measurement timeline stays on track, and handles any issues that occur throughout a cycle.

Timeline

The timeline for PERM is based on a measurement year of July 1 through the following June 30 to be in line with state-specific reporting.

Exhibit 2 provides a timeline of major PERM activities for the states, SC, ERC, and RC for claims activities and a high-level timeline. This manual addresses specific universe and sampling due dates in [Section III – PERM Sampling Universe](#). See [Appendix C](#) for a detailed PERM Timeline.

Exhibit 2: PERM Process Estimated Timeline



Systems Access/Use of Data

The RC, ERC, and SC require access to sampling units stored in states’ MMIS and eligibility systems. [Section 1902 \(a\)\(6\) of the Act](#) requires the state agency to make such reports, in such form and containing such information as the Secretary may require and comply with such provisions as the Secretary may find necessary to assure the correctness and verification of such

reports. [42 CFR § 430.32](#) is a parallel authority. CMS is operating the PERM program under the final rule [FR/Vol. 82, No. 127](#) as published on July 5, 2017 and in [42 CFR § 431](#) and [42 CFR § 457](#).

- The RC, ERC, and SC are business associates of CMS pursuant to [45 CFR § 164.502 \(e\)](#) and under contract to perform the scope of work for the PERM project; the contractors were required to sign a business associate agreement as specified at [45 CFR § 164.504 \(e\)](#); CMS contractors must abide by the terms and conditions of these contractual agreements, which incorporate HIPAA and Privacy Act of 1974 provisions requiring security measures and imposing limitation on use

Record Retention Requirements

PERM abides by a singular record retention requirement for all of the following items:

Inputs: Outgoing correspondence for reference of case activity, posting recoveries, account balances, recoupment activities, CMS-mandated reports and letters; eligible debts for collection; overpayment data from providers; (MSP, Medicaid/CHIP claims data from states, and medical records from providers.

Master Files: Collection of inputs described above, which includes outgoing correspondence for reference of case activity, recoveries, account balances, audit trail of recoupment activities, CMS-mandated reports and letters, eligible debts referred to Treasury for collection; provider overpayments; MSP, Medicaid/CHIP claims data, and medical records from providers.

Outputs: CMS Mandated Reports, Letters, and Collection Referrals.

Ad hoc Reports: Reports generated for a special purpose or immediate need.

Other Records: Records consisting of documentation and information that support compliance and integrity activities and functions, including:

- Plans and agreements.
- Administrative records, records related to surveys, reviews, and audits.
- Reports.
- Legal records related to operations and program integrity.

Disposition of records, to include collected documentation and information, follows a [CMS approved Records Schedule](#).

III. PERM Sampling Universe

The PERM program bases its methodology on sampling and reviewing individual payments from a universe of original, federally matched, and fully adjudicated Medicaid and CHIP payments the states made on behalf of individual beneficiaries to providers and other entities for medical services rendered. The RC and ERC review these samples for improper payment findings; the SC extrapolates state- and national-level improper payments from the findings the RC and ERC identify.

A complete and accurate universe is the foundation of PERM sampling and improper payment rate estimation. The PERM program intends for the improper payment rates to be representative of all Medicaid and CHIP payments and the methodology is predicated on being consistent across states in a given cycle. The PERM states and the SC work together to define and compile the PERM sampling universe.

This section describes the specifications of the PERM sampling universe, the types of payments included in and excluded from the universe, and the process of submitting data to the SC for sampling. Specific instructions for compiling and submitting PERM-compliant universe data are available on the CMS website.

A. Claim Universe Definitions

The PERM program bases its universe specifications on PIIA statutory requirements, OMB guidance, and the PERM federal regulations. The scope of the PERM universe is bound by the following parameters, each of which is described in more detail below.

- Payment amount.
- Payment date.
- Program type.

Payment Amount

PIIA defines an improper payment as a payment a payer made in the incorrect amount, which includes both overpayments and underpayments.³ While non-zero-dollar payments made by the states include the potential for overpayments and underpayments, denials and zero-dollar payments also include the potential for underpayments. Therefore, all three types of payments must be included in the PERM universe, provided they meet all other criteria for inclusion.

While the majority of the PERM universe is comprised of non-zero-dollar payments, denials and zero-dollar payments are subject to sampling and review as well. Denials are claims that have been fully adjudicated but denied for payment. Zero-dollar claims are those that have been approved for payment, but, due to third-party or beneficiary obligation, for which the state bears no liability.

The PERM improper payment rate is based on the total computable amount of the payment adjusted to the federal level using each claim's FMAP rate. The total computable amount includes federal and state or local shares and does not include beneficiary (e.g., copays and coinsurance), third-party (e.g., Medicare, workers' compensation), and other (e.g., taxes paid on waiver services) liability. For certain types of payments made by the states, the system may not retain the total computable amount (e.g., payments made by certified match or in-kind services). For all payments subject to PERM review, states must include the total computable amount in the PERM universe. [Section IV](#) of this manual describes the PERM sampling process, including: PERM sampling units; the sampling process (including determining the size of the sample); stratification; and improper payment estimation. The information included in Section IV

³ [Payment Integrity Information Act of 2019](#)

underscores the importance of the correct total computable amount in the PERM universe.

Payment Date

The PERM sampling universe includes payments originally made or denied during the period under review. The universe includes claims and payments originally made or denied between July 1 and June 30. The exact year depends on the year in which results are reported. See ***Exhibit 3*** for examples of sampling periods based on PERM cycles.

Exhibit 3: PERM Sampling Timeframes

PERM Cycle	Sampling Begin Date	Sampling End Date
R Y24 – Cycle 3	July 1, 2022	June 30, 2023
R Y25 – Cycle 1	July 1, 2023	June 30, 2024
R Y26 – Cycle 2	July 1, 2024	June 30, 2025

To ensure consistency across states, PERM relies on the original paid or denial date to determine whether a payment is included in a given cycle. If a state originally pays a claim during the cycle under review, but adjusts the claim after the cycle, the claim is included in the PERM universe based on the original date of payment. Conversely, if a claim’s original date of payment is prior to the PERM cycle, but an adjustment falls within the cycle, the claim is not included in PERM, again based on the original date of payment. See [Section 3.C.a](#) for more information on the treatment of adjustments in PERM.

If states make payments for prospective or retrospective periods of coverage, the payment should be included as of the actual date of payment. For example, if a state being measured in the July 1, 2024, to June 30, 2025 cycle makes a retrospective capitation payment on July 5, 2024, for coverage in June 2024, the payment should be included in PERM, even though the state is purchasing coverage for a period outside the cycle being measured. Conversely, if a state in the same cycle makes a prospective capitation payment on June 30, 2024, for coverage in July 2024, the payment should not be included in PERM. Even though coverage is being purchased for a period inside the cycle being measured, the date of payment falls outside the measurement year.

Program Type

OMB guidance directs CMS to measure Medicaid and CHIP as programs susceptible to significant improper payments. Therefore, the PERM program creates separate universes for Medicaid and CHIP payments so that PERM can estimate independent improper payment rates for each program. PERM also separates each program into FFS and MC components based on capitation arrangements.

PERM divides universes based on the FFP match received for the payments. The Medicaid universe includes payments matched with Title XIX, and the CHIP universe includes payments matched with Title XXI funds. The CHIP universe contains payments made under both stand-

alone and Medicaid expansion-type CHIP (where beneficiaries are enrolled in Medicaid, but their claims are matched with Title XXI FFP).

For denials and zero-dollar paid claims, PERM determines the appropriate universe by the type of FFP, had the claims not been denied or had the claim not had other liability. Similar to claims and payments for which the state has financial liability, it is imperative to identify the appropriate universe for denials and zero-dollar claims.

Services Matched with Both Title XIX and Title XXI Funds

States may have services that are matched with both Title XIX and Title XXI funds. States must bring these payments to the SC's attention prior to the start of the PERM cycle so the SC can identify the most appropriate universe placement for these payments.

Denials that Cannot Be Identified as Medicaid or CHIP

States may have denials for which the type of FFP—had the claims not been denied—cannot be determined. States must bring these payments to the SC's attention prior to the start of the PERM cycle so the SC can identify the most appropriate universe for these payments.

B. FFS and MC Components

This section discusses the two components of Medicaid and CHIP universes—FFS and MC. The primary factor in determining whether a payment is FFS or MC is which entity holds the underlying risk for that payment. If the claim represents a payment for a medical service paid directly by the state, the state holds the risk, and the payment would typically be classified as FFS. If the payment is a flat payment (e.g., capitation payment) to a vendor (e.g., MCO) that, in turn, is responsible for paying for any services, the vendor holds the risk, and that flat payment would be considered MC. These two components are discussed in more detail below.

FFS Payments

FFS includes the traditional method of paying for medical services under which the state pays providers for each service rendered to individual beneficiaries. FFS payments in Medicaid and CHIP generally include inpatient/outpatient hospital, professional, clinic, dental, lab/X-ray/DME, pharmacy, and long-term services and supports claims. These payments can be for FFS beneficiaries or MC members, if the service is not included in the MC capitated agreement and is paid under FFS. These claims are typically processed through the MMIS or other payment systems, including other state agencies and third-party vendors. In order to be considered FFS, however, the actual cost of the claim should be paid by the state through a pass-through or administrative services agreement, where the state is still at full risk for the cost of the claims.

FFS also includes non-MC fixed payments to providers, which are described below in more detail. There are also payments to MCOs that would be included in FFS, such as reinsurance or stop-loss payments made for MC enrollees. Like all other PERM payments, these payments must be matched with Title XIX or Title XXI funds and must meet all other criteria for inclusion in PERM. These payments must also be made on behalf of individual beneficiaries to purchase

medical services.

Payments made to registered non-risk PIHPs/PAHPs or MCOs under an Administrative Services Only arrangement would be included in FFS. These payments directly reimburse the vendor for claims that were paid; therefore, the state maintains the risk.

Aggregate payments, which are described in more detail below, are always considered FFS, regardless of the risk. If a full-risk payment to an MCO is for multiple beneficiaries and cannot be broken out to individual beneficiary payments, it is considered an aggregate payment and included in FFS.

Managed Care Payments

MC is a delivery system in which a state contracts with MCOs, on a full or partial-risk basis, to deliver health services through a specified network of providers. The state pays a fixed amount, or capitation rate, to the MCO, which is then responsible for managing the care of the member (including case management) and contracting and reimbursing providers for specific services delivered. The MCO, not the state, maintains the financial risk. MC payments, which are subject to federal match, can include capitation payments made for a comprehensive package of services (full capitation), for a limited package of services (partial capitation), or for specialty MC programs for which the capitated provider is at risk (e.g., PACE and behavioral health). The actual claims paid by the MCOs to the providers are not within the scope of the definition of payments by PIAA and are, therefore, not part of PERM.

The PERM MC universe also includes supplemental negotiated rate payments made to MCOs on behalf of individual MC enrollees for specific conditions or situations. These can include maternity “kick” payments, delivery supplemental payments, and newborn supplemental payments. These payments can cover multiple services and can be billed to the state and processed by the state as FFS claims. The MCO still maintains the financial risk for the services included in that payment. As a result, the payment is considered MC.

Small FFS or MC Universes

States may not have payments for one of the components—MC or FFS. In addition, there are instances where one component is very small in terms of expenditures relative to the other component and overall state program (Medicaid or CHIP) expenditures included in PERM. An example of a very small MC universe might occur if PACE is the only MC program in Medicaid or CHIP that is entirely in MC, except for a small vaccination program, which is paid by FFS. Applying the normal rules of universe creation to a small component will result in a very large proportion or all of the payments in the component being sampled. In that case, the component improper payment rate will essentially be the improper payment rate of the single small program or payment type. This would result in a much higher level of scrutiny to this small program than what is applied to other services or programs and would ascribe much more importance to the associated improper payment rate (by terming it a “component” improper payment rate) than a program of this size deserves.

PERM combines the very small component and the large single universe, where the small

component accounts for less than two percent of total expenditures for the state’s program. For instance, if the total expenditures associated with the state’s only MC program is less than two percent of the total Medicaid expenditure, then MC would be included in the Medicaid FFS universe.

States must bring possible small components to the SC’s attention prior to the start of the PERM cycle so that the most appropriate universe for these payments can be identified.

Non-Managed Care Fixed Payments

Besides MC capitation payments and FFS claims, Medicaid and CHIP make a variety of other types of payments on behalf of individual beneficiaries that are subject to PERM review. These could include non-risk capitated Per-Member-Per-Month payments for programs such as PCCM, disease management, and NEMT. Additionally, payments made to individuals or health plans through HIPP programs, reinsurance or stop-loss payments to MCOs, and drug administration capitations to nursing facilities are also included in PERM. The PERM sampling universe also includes premium payments made by the states toward Medicare Part A and Part B for dual-eligible beneficiaries. The SC collects these premium payment data from CMS and not from the states.

States need to discuss certain payments, such as special incentive payments to providers or payments made under an 1115 waiver to non-enrolled beneficiaries, with CMS and the SC to determine if they are appropriate for inclusion in the PERM universe. Although there may be exceptions, these payments are typically included in the FFS universe as “fixed payments.”

Aggregate Payments

While most Medicaid and CHIP payments are made at the beneficiary level, states may also calculate and pay for certain services on behalf of a group of beneficiaries. PERM broadly refers to these as “aggregate payments.” Unless otherwise specified by CMS, aggregate payments for services are subject to sampling and review in PERM. These payments are included in the PERM universe regardless of whether the state claims FFP at the medical services match rate or as an allowable administrative cost.

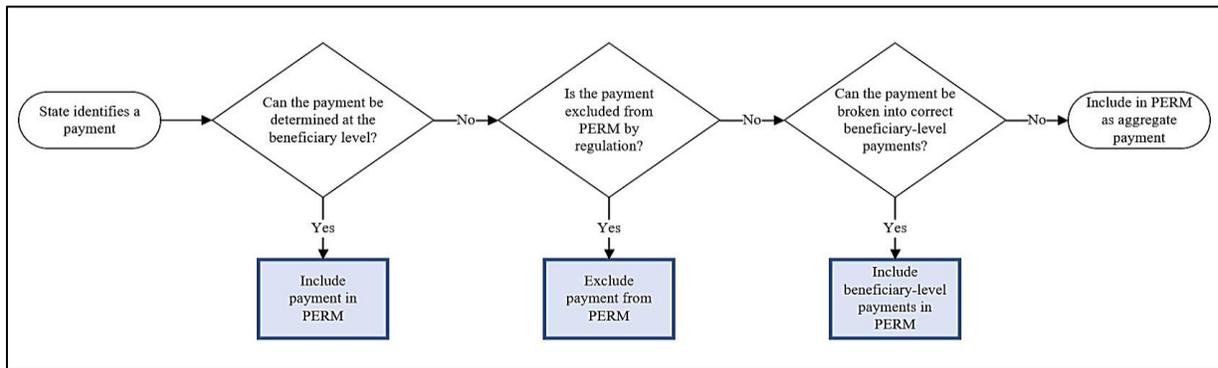
Examples of aggregate payments are: reimbursement to counties for NEMT services provided to all Medicaid beneficiaries residing in that county; contractually agreed-upon aggregate payments to a broker for provision of transportation services; and fees paid to a case management vendor based on the number of beneficiaries enrolled in the program each month.

In certain cases, states may determine payments at the individual level but maintain payment records at the aggregate or invoice level. In these cases, CMS and the SC will work with the state to determine how the payment should be submitted and reviewed for PERM. In assessing whether a payment should be submitted as aggregate or at a beneficiary level, the SC determines if the payment can be attributed to specific beneficiaries. If not, the SC would need to take the payments as aggregate in order to represent the payment at the correct sampling unit level. For example, some states make additional or “bump” payments to providers for Title XIX or Title XXI beneficiaries based on the provider’s location or specialty. In some cases, there is no way

to know how much the provider gets paid per each specific beneficiary, as electronic records may only be available at the provider level. Thus, these payments would be submitted at the aggregate payment level. However, if there is information available about the beneficiaries on behalf of which the payments were made, the SC can work with the state to see if beneficiary-level claims can be created.

Aggregate payments lack fundamental consistency, as payment methodologies and documentation can vary significantly across states. To assist in handling aggregate payments consistently and appropriately for PERM, CMS developed the following framework displayed in *Exhibit 4*.

Exhibit 44: PERM Aggregate Payment Framework



The framework walks through each step of the process used to determine whether a PERM payment should be submitted in aggregate form for inclusion in the universe. Each step has a decision point that requires state input on the payment, its methodology, and its availability.

Answers to each question will assist the SC in working with the state on how to address each individual aggregate payment.

States should work with CMS and the SC to determine how payments should be submitted and reviewed for PERM. It is important to note that the definition of aggregate payments continues to evolve for PERM as states continue to develop innovative payment methodologies. CMS, the SC, and the RC will continue to evaluate which payments are considered aggregate payments for PERM. It is possible that an aggregate payment not included for PERM in a past cycle could be determined to be an aggregate payment for inclusion in a future cycle.

Health Reform-related and Other Incentive Payments

In light of the federal and state-initiated health reform activities, many states have implemented or plan to implement new programs to support efficiency and quality in health care delivery using Title XIX and/or Title XXI funds. If these payments are calculated at the beneficiary level, they likely are to be included in the PERM universe, even if they are made in aggregate. For example, many states have made increased or “bump” payments to primary care or clinic providers. These payments are often made in aggregate but were calculated at the beneficiary

level and were matched by federal funds. Therefore, they are subject to sampling and review under PERM.

C. PERM Exclusions

The PERM sampling universe is guided by the rule that each beneficiary-specific payment matched with Title XIX or Title XXI funds should have one chance, and only one chance, of being sampled. Therefore, it is imperative that each payment is included in the PERM universe only once.

The PERM sampling universes must contain payments that are original, federally matched, and fully adjudicated and approved or denied for payment. This means that adjustments to original payments, state-only payments, and payments not fully adjudicated are excluded from the PERM universes. By PERM regulation, payments made for solely administrative purposes and certain other types of payments made to providers are excluded from the PERM sampling universes. Further excluded from the PERM universes are encounter records for capitation or other encounter-based payments. In this section, these PERM exclusions are described in detail.

Adjustments

Since each payment is included in the PERM universe once and only once, the routine PERM universe may not have both the original payment and any related adjustments. These claims may be included as part of the PERM+ data submission, with the state providing guidance on how the SC can identify and remove adjustments. For consistency across states and programs, PERM sampling universes include only original payments. Therefore, all forms of adjustments, including voids, replacements, and adjusted claims or payments, must be excluded from the sampling universe.

In PERM, the dollar amount in error is the difference between what was paid and what should have been paid. The original payment amount is used to determine what was paid and is compared to what should have been paid. However, if a payment is adjusted within 60 days of the original payment date, the adjusted amount will be used to determine what was paid and will be compared to what should have been paid. Adjustments made outside of this 60-day window will not be considered. When reviewers conduct DP reviews, they collect and consider all adjustments made within 60 days of the payment date. For example, for the claim originally paid on September 15, 2024, PERM will consider any adjustments made prior to November 13, 2024.

Commonly, claims adjustments for Medicaid and CHIP are made through individual adjustments and mass adjustments, described below. On rare occasions, the state may have replacement claims as a result of a void-and-replace form of adjustment, which cannot be distinguished from the original payments. The state must bring such instances to the attention of CMS and the SC so that the appropriate inclusion and exclusion strategy may be identified.

Individual Claims Adjustments

In most cases, the adjusted claims are processed to correct an error. Adjustments to individual claims can be initiated by either the provider or the payer.

- Provider-initiated individual adjustments: A provider can submit a request for a claim adjustment for a variety of reasons including, but not limited to: errors in number of units or medical codes billed; incorrect beneficiary information; and incorrect medical/service codes.
- State-initiated individual adjustments: States may also adjust claims on an individual basis as a result of claims audit, review, surveillance, etc.

Mass Adjustments

States, on occasion, make mass adjustments to the payments they previously made to providers. Two of the most common reasons for mass adjustments are:

- *Changes in reimbursement rates to providers:* In some cases, provider fee adjustments become effective prior to the time when the claims payment system can be adjusted to reflect the change in fee schedule. If a state makes a payment according to an old payment schedule after the effective date of the updated payment schedule, either because the effective date was retroactive or because the system changes necessary to make the new payment were not completed by the effective date, this payment, even if outside the 60-day window for adjustments, will not be considered an error in the PERM review.
 - A typical example is when regulations mandate fee increases or decreases, and the necessary changes to the claims payment system cannot be implemented by the effective date of the fee schedule change. The state will typically make a mass adjustment to the paid claims to ensure that the providers are reimbursed the amount mandated by the updated regulations.
 - Another example includes providers that successfully sue the state for having inadequate fees for certain services, in violation of the Title XIX statutory requirement that payment rates be consistent with economy, efficiency, and quality of services. If the judicial remedy includes retroactive fee increases, the state is obligated to make mass adjustments.
 - A final example is rate or benefit changes through SPAs where the effective date of the SPA is prior to the approval date. States typically make mass adjustments so that the provider reimbursements reflect the changes in policy.
- *Cost-based payment rates:* In many states, certain Medicaid payment rates, such as institutional (hospital and nursing facility), FQHCs, and RHCs are cost-based. For these providers, a cost settlement is completed to establish the final cost-based rate. A mass adjustment is then made to account for the difference between the interim and final rates. Similarly to retroactive rate changes, PERM will review the payment based on the pricing schedule on file at the time the payment was made and will not consider it an error if prices are changed retroactively due to cost settlement outside of the 60-day adjustment timeframe.

State-Only Payments

The PERM universes include only payments matched with federal Title XIX or Title XXI funds. Payments that do not receive either are identified as state-only for PERM purposes and are

excluded from the sampling universes. This is because the PERM program only reviews payments that have federal liability for potential improper payments. The state may have programs for which no federal match is received. The state may also make payments on behalf of certain groups of beneficiaries but receive no federal match. For the latter example, all payments for these beneficiaries are considered as state-only.

Payments Not Fully Adjudicated

The PERM universes include only claims that have been fully adjudicated. CMS defines a fully adjudicated claim as one that has been reviewed by a person or a system completely and has been approved or denied for payment. Claims that either are in process or are suspended for review are not considered to be fully adjudicated. Rejected claims (e.g., claim batches rejected by a pre-processor) that never made it to the state's adjudication process are also not included in the PERM universes.

States may have certain types of claims where the rejected claims cannot be distinguished from the denied claims. The state must bring these to the attention of CMS and the SC so that the appropriate inclusion and exclusion strategy may be identified.

Administrative Payments

PERM universes include only claims and payments representing services rendered to individual beneficiaries or capitation payments purchasing a package of services on behalf of individual beneficiaries. These payments could be matched either at the medical services match rate or as an allowable administrative cost.

PERM universes do not include payments solely made for administrative functions, such as payments to fiscal agents, salaries of state employees, or funding for program outreach. In instances where rates blend administrative and service payments, the entire payment must be included in the PERM universe.

Payments Excluded by Regulation

The PERM regulation explicitly excludes specific types of payments from the universes. These typically do not represent payments made on behalf of individuals for services. Regulatory exclusions include:

- Disproportionate Share Hospital payments.
- Drug rebates.
- Grants to state agencies or local health departments.
- Graduate Medical Education payments made as a lump-sum.
- Cost-based reconciliations to non-profit providers or FQHCs not tied to individual claims.

Additionally, PERM excludes ELE cases from the eligibility reviews per CHIPRA. PERM also excludes denied claims that were denied by the state because no beneficiary information was available on the claim from the eligibility reviews. Claims that were denied based upon the state's determination of the case eligibility are subject to review.

Encounter Data

The PERM universes include only true payment records based on which federal match is received. Therefore, encounter data or “shadow claims” are excluded from the PERM universes. For PERM purposes, encounter data are defined as informational-only records submitted to a state by a provider or an MCO for services covered under a MC capitation or encounter payment. While these are beneficiary-specific, encounter data do not represent actual payments made by the state. Therefore, they are excluded from the PERM universes.

States often collect encounter data to track utilization, assess access to care, and possibly compute risk adjustment factors for at-risk MCOs. States may also require encounter data from FQHCs, RHCs, non-risk PIHPs/PAHPs, and IHS clinics paid at an encounter rate. Further examples of encounter claims include records for state-supplied vaccines and shadow claims for programs paid by Certified Public Expenditure.

D. PERM Data Submission

CMS requires each PERM state to submit a quarterly universe of all PERM-compliant Medicaid and CHIP payments from which the SC will select samples. In this section, the methods of PERM data submission, transmission via STEP, documentation, claims data submission due dates, claims data quality review, and data security are discussed.

Methods

There are two methods of data submission available to the states—Routine PERM and PERM+. States electing either option must continue to use it throughout the cycle. There may be some situations where a hybrid approach between PERM + and Routine PERM is necessary, and the SC will discuss that situation on a state-by-state basis.

Routine PERM

The Routine PERM data submission process requires two data submissions from the states. The first data submission contains complete Medicaid and CHIP universes. CMS requires that the universe data conform to the list of requirements described above to ensure consistency across states. The submission must not include any of the PERM exclusions. This data submission facilitates the SC’s creation of clean universes from which samples can be selected. The second data submission contains information required for completion of the details for the sampled FFS payments, including fields such as diagnosis codes, procedure/Current Procedural Terminology (CPT) codes, and attending provider information. These sample details are required for DP review and MRRs.

Please refer to the relevant cycle page on the [CMS PERM website](#) for the Routine PERM Universe and Details Data Submission instructions.

PERM+

PERM+ is a data submission process developed by CMS to simplify PERM for the participating states. Through PERM+, states submit relatively raw quarterly claims, beneficiary, and provider data. Each state, in conjunction with CMS, decides if data will be submitted via the PERM+ method prior to the SC's Intake Meeting with the state. States must notify CMS by June 15 prior to the PERM cycle being measured if they intend to use PERM+ to submit some or all of their data.

Unlike in Routine PERM, in PERM+, the SC is responsible for developing the universes by removing PERM exclusions with the states' guidance. States submitting under PERM+ do not have to develop the details for sampled claims, since the SC receives all necessary claim, provider, and beneficiary information with the one data submission and is able to append them to the sampled claims. If the SC has inadequate information for the sampled claims or requires clarification, the states will be contacted, as necessary.

Please refer to the relevant cycle page on the [CMS PERM website](#) for the PERM+ Data Submission instructions.

Transmission via SFTP

Data transmission is a vital part of the state's work with the SC. To be able to send and receive files, states need a clear understanding of how the SC's SFTP functions and how to quickly and easily troubleshoot any issues that may arise. Data transmitted via the SC's SFTP includes, but is not limited to: quarterly data transmissions from states; claims-specific questions from the SC containing PHI/PII; and sampler/details files from the SC.

States should never use email to transmit documentation containing PII or PHI. The SC uses xfiles as the secure file transfer solution to send or receive documentation containing PHI or PII. Examples of documentation that the state may transmit to the SC include:

- Claims and payment data.
- Financial transactions.
- Responses to questions that contain beneficiary-specific information.

The state may choose to have multiple users establish access to the SC's SFTP or may need to have separate folders created within the state folder. Users can establish accounts at any point during the cycle, but it is recommended states establish accounts before the Quarter 1 data submission begins for the state's current cycle to troubleshoot any access issues. The SC also recommends submission of test data ahead of the Quarter 1 data to ensure the SFTP can be accessed and that there are no issues in file transmission.

The SC will send instructions to states at the beginning of the cycle to: help states register, access the site, and submit data; change the SFTP password; and find support if needed. The instructions contain directions and screenshots to address all steps in the process. If at any time state representatives need support or have questions regarding the SC SFTP, they should reach out to their Data Manager or contact the general PERM SC inbox at PERM_SC@lewin.com.

Documentation

Data documentation is a critical component of each PERM submission. Complete documentation saves time by reducing errors, re-work, and questions from the SC to the states. At a minimum, each PERM submission should be accompanied by:

- Transmission cover sheet : This document provides information about the files sent to the SC.
- Control totals: These totals help the SC ensure that no data have been lost or corrupted during transmission.
- Data dictionary: This document provides decode information for state-specific values in the PERM data submission.
- File layout: This document lists the fields included in the data submission along with their type, format, and length.
- Variable Crosswalk: This document lists all the fields in the data submission along with the variable identified in the state system that will populate the field.

Claims Data Submission Due Dates

PERM data submissions are due to the SC 15 days after the end of each quarter as shown in *Exhibit 5*, unless the due date falls on a weekend or federal holiday, in which case the due date is the next business day. These dates are applicable for both Routine PERM and PERM+ methods of submission.

Exhibit 5: Claims Data Submission Due Dates

Quarter	Claim Date Paid	Data Submission Due
Quarter 1	July 1–September 30	October 15
Quarter 2	October 1–December 31	January 15
Quarter 3	January 1– March 31	April 15
Quarter 4	April 1–June 30	July 15

Claims Data Quality Review

States are required to review the PERM data prior to submission and certify the accuracy and validity of the submission. Thorough data quality review by the states prior to PERM submission saves time by reducing errors, re-work, and questions from the SC. States are urged to compare expenditures represented in the PERM submission with their CMS-64/21 reports to ensure payments that should be included in the PERM submission are included. Refer to the Data Submission Instructions relevant to your cycle on the [CMS PERM website](#) for instructions and guidance on data quality review and on comparing PERM data to CMS Financial Management Reports.

Universe QC Process

The SC performs a series of QC checks to ensure that the states' PERM data meet PERM specifications as defined in regulation and the PERM Data Submission Instructions for both Routine and PERM+ states. The PERM universe data must meet all PERM specifications to support the SC's review of the PERM data to ensure that the SC selects a sample from a compliant PERM universe. Major activities performed as part of the QC checks include standardization and validation prior to sampling and review, as defined in the next section.

Data Standardization

- The layouts of the submitted files match those stated in the documentation to ensure that the data can be read correctly.
- If the submission does not conform to the standard layout recommended by the Routine PERM or PERM+ Data Submission Instructions, the SC creates standard field names and standard values based on the state-submitted data, so the SC can compare data between states, quarters, and RYs; to perform this step, the SC may have questions for the state, which must be answered in a timely manner.

Data Validation

- The control totals in terms of the number of lines and the total paid amount the state provides in the Transmission Cover Sheet during data submission matches the control totals the SC calculates.
- The claims data contain core fields, and each field contains valid values that are listed in the data dictionary.
- For the Routine PERM states, the data do not contain adjustments, informational-only lines, state-only payments, and other payments/records that are not subject to PERM review; for the PERM+ states, the data may contain these exclusions, but the SC will request the state's confirmation prior to removing them from the universe.
- There is a reasonable and expected distribution of payment units and amounts by claim type, provider type, paid date, and across quarters.
- Each record contains valid values for Internal Control Number/Transaction Control Number (ICN/TCN), paid amount, paid date, claim type, payment level, and provider type.
- There are no duplicate records, negative paid amounts, denials associated with non-zero payment amounts, paid dates outside the quarter, or missing lines for claims paid at the line level.
- The submitted data reflect information the state provided during the Intake Meeting, in state documentation, and in other communication

The SC also performs the following QC checks specific to PERM+ states:

- The provider and beneficiary data files contain core fields necessary for DP and MR.
- Information for providers and beneficiaries with claim records in the claims files are available in the provider and beneficiary files.

The PERM QC process involves SC review of data at multiple points in the process to ensure:

- Adherence to all PERM specifications.

- Sample is selected from a complete, correct, and compliant universe.
- Each PERM record has one and only one chance of being sampled.
- Sample and details data contain all the necessary information for efficient DP and MR.

During the course of the data review, the SC may seek clarification about the data from the state. These questions can range from simple questions, such as needing file formats or data dictionaries, to more complex ones regarding missing claims and payment data or serious data irregularities. A timeframe for an expected response from the state will be included in communications. The time required for a response from the state varies from a few days to more than a week, depending on the number and complexity of the clarifications requested. It is critical for the state to respond to SC questions within the required timeframes, as delays in the universe QC process could lead to delays later in the PERM process, such as sampling, MRRs, DP reviews, and MRs.

Comparison of PERM Data Submissions to the CMS-64/21 Reports

As a part of the PERM process, the SC compares each state's PERM universe data to the state's CMS-64 and, as applicable, CMS-21 reports. This ensures the PERM universe data contain all claims and payments for services provided to individual beneficiaries in accordance with PERM regulation and guidance.

The SC reviews the total dollar amounts reported on the quarterly CMS-64, CMS-64 waiver reports, and CMS-64 Newly and Not Newly forms for Medicaid and the CMS-64.21U, CMS-64.21 waiver, and CMS-21 for CHIP, depending on the reports the state submits. The SC then compares total dollars reported to CMS, less any lines the SC can exclude—such as those for administrative payments—to the total dollars included in the PERM sampling universes for each quarter and annually. CMS defines a reasonable level of difference for this comparison as no more than a five percent difference in total dollars for the entire RY for each program and no more than a 15% difference per quarter between the PERM data and CMS reports.

If the comparison between the PERM universe and the CMS reports results in a percentage difference greater than the established thresholds, the SC will work with the state to identify reasons for the discrepancy. The most common sources for differences are:

- Significant claims adjustments.
- Prior period adjustments.
- Non-beneficiary specific payments included in service lines of the CMS reports.

To resolve these differences, the SC provides the state with a summary of the comparison to help the state identify potential sources of the differences. The SC asks the state to identify potential sources of the difference, to involve relevant state staff (e.g., PERM staff, financial staff responsible for the CMS report submissions, and relevant policy staff), and to attend all scheduled calls. The SC may also request holding one or more conference calls with the state to discuss and resolve potential sources of the difference. Prior to these conversations, the SC will provide the state with a summary of the comparison findings.

Once the state has identified possible sources of discrepancies, the SC asks the state to provide the financial information associated with the discrepancies (e.g., dollar amounts). The SC uses this information to adjust the comparison in an effort to achieve a percentage difference between the PERM universe and the CMS reports that is within the threshold identified in the section above.

Data Security

Under PERM, states submit data that contain PHI and PII and under HIPAA, CMS, its contractors, and states are all responsible for ensuring the security of PHI and PII that they maintain, transmit, disclose, or dispose. Information security requirements must safeguard against the potential breaches of ePHI and PHI. CMS requires states, its contractors, and other business associates to adhere to federal standards for the adequate encryption of PHI or PII prior to transmission and to ensure that any passwords are sent securely and separately from the transmitted data, regardless of the method of transmission. PHI or PII should **never** be sent by email.

Under HIPAA, covered entities must ensure the secure transfer of PHI and PII contained in any data transmissions. To meet this requirement, CMS requires all state data transfers containing PHI and PII be encrypted with software that is compliant with the Federal Information Processing Standards 140-2 and validated by the National Institute of Standards and Technology module.⁴ The software should also have key management, which allows the state's system administrator to have the authority to unlock all encrypted files from the state's system. This method prevents the necessity of sharing the password with others at the state if the state contact person sending the data to the contractor is unavailable to provide the key.

In the event of a breach of PHI or PII, CMS requires states, its contractors, and other business associates to adhere to the breach notification rules as mandated under the Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009.⁵

The CMS contractors will provide states with instructions on data submission that meet CMS security requirements. Providing systems access to CMS and its contractors is required per [42 CFR § 431.970](#). CMS and its contractors will work with states to meet appropriate levels of training requirements and security measures set by the state.

IV. PERM Sampling Process

The goal of PERM is to measure and report an unbiased estimate of the true improper payment rates of Medicaid and CHIP. Because it would be impossible to review the accuracy of every Medicaid and CHIP payment, CMS uses a statistically valid methodology to select small random samples of payments from the Medicaid and CHIP universes and then extrapolates from

⁴ [FIPS 140-2 and NIST module](#)

⁵ [The HIPAA Breach Notification Rule](#), released by OCR/HHS, applies to HIPAA covered entities; [The Health Breach Notification Rule](#), released by the FTC, applies to non-HIPAA covered entities

the review findings for the samples to estimate the improper payment rate for the program universes.

PERM is designed to fulfill the requirements of PIIA by calculating Medicaid and CHIP improper payment rates that meet certain precision and confidence requirements. For each state, separate improper payment rates are estimated for Medicaid and CHIP based on a sample of payments. If a state has both FFS and MC, separate component improper payment rates are estimated then weighted together according to expenditures. While a state may not have both the FFS and MC components for each program, all states will have an eligibility component for both programs. Included in this section are descriptions of:

- Sampling Units.
- Claims Sampling process (including sample size determination).
 - Stratification.

A. Sampling Units

The PERM methodology is based on sampling and review of individual payments from a universe of state Medicaid and CHIP payments (as specified in the previous section) to identify payment errors, from which state and national-level program improper payment rates are extrapolated. Each payment in the PERM universe, including FFS, MC, or aggregate, is considered an individual “unit” for sampling purposes. Each sampling unit is the smallest level of individually identifiable payment and, as discussed previously, must have one and only one chance of being sampled. Therefore, it is imperative to ensure that the universe does not have multiple occurrences of a sampling unit.

General Sampling Unit Definitions

For most individual beneficiary-level claims and payments, the sampling unit is a claim, line item, MC capitation payment, fixed payment, or other individually priced service tied to a single beneficiary. If a state calculates the payment amount for a claim at the line item or “detail” level, the line is the sampling unit. The state must include all paid (including zero-dollar paid) and denied lines for that claim in the PERM universe. For example, physician claims usually report an individually priced service on each line of a claim (e.g., a claim may have five lines representing five individually priced services). Since the paid amount for each line on the claim is determined independently of the other lines, the state must include each line in the PERM universe.

If the payment amount is calculated at the claim level (e.g., a DRG, per diem, or encounter-based payment), the sampling unit is the header record containing only the claim-level information. A hospital claim that pays on a DRG basis may include 20 additional revenue lines, but the paid amount for all of the services is calculated based on the DRG reported on the header. In this case, only one record representing the header-level payment for the DRG should be in the PERM sampling universe. The 20 lines on the claim are informational details because they are not priced separately and, therefore, are not considered sampling units.

Claim-specific Exceptions

States may need to identify claim-specific exceptions to payment-level rules. For example, out-of-state hospitals are excluded from the DRG methodology, and each claim detail is paid on a percent-of-charges basis. In this case, the out-of-state hospital inpatient claims would be included in the PERM universe at the line level even though all other hospital inpatient claims are included at the header level. Other claim/provider types where there are often exceptions to the general header/detail payment rules include: Medicare crossover claims; claims from FQHCs, RHCs, and IHS clinics; and claims from state-owned facilities.

TPL and beneficiary cost-sharing (copayment and coinsurance) may also affect the level at which a PERM sampling unit is determined. If, for a claim paid at the detail or line level, TPL or beneficiary cost-sharing is deducted from the overall claim's allowed charge, the particular claim with TPL must be included in the PERM universe at the header level. This is because the sum of the details payment amount is not equal to the amount reimbursed by the state. In this example, the claim would be included in the PERM universe as a header-level sampling unit to reflect the total computable amount for the claim.

The state may also make beneficiary level Per-Member-Per-Month, Per-Member-Per-Week, supplemental, or flat fee payment for non-full risk services, such as transportation or wrap-around payments. These payments are usually set as a fixed payment sampling unit in PERM. CMS, the SC, the RC, and the state may coordinate to determine which payments fall under this classification.

For aggregate payments, the sampling unit for PERM is generally the lowest level for which a payment entry (record, invoice, or claim that the state uses to determine the payment amount) is available. CMS, the SC, the RC, and the state may need to work together to determine the appropriate sampling unit for aggregate payments and the appropriate review methodologies.

B. Claims Sampling Process

PERM aims to report a national improper payment rate bound by a 95% confidence interval of three percentage points in either direction of the estimate. That is, the sample must be large enough that, given standard statistical assumptions, one can be 95% confident that the improper payment rate for the sample is within plus or minus three percentage points of the true improper payment rate for the universe. Selecting a larger sample size can increase the confidence that the sample improper payment rate is closer to the universe improper payment rate and/or decrease the size of the range around the estimate.

Although separate samples are drawn for Medicaid and CHIP, the procedures for sampling are the same for both programs. This section distinguishes between Medicaid and CHIP only when differences occur.

A yearly sample size will be determined prior to sampling. The cycle sample size will be distributed among the cycle states depending on individual state precision needs, improper payment rates, and expenditures. After the allocation of the cycle sample across states has been

performed, every state will have an FFS, MC, and eligibility sample (unless a state does not have an FFS or MC program and, would therefore, only have the FFS or MC sampling and an eligibility sample). The claims (FFS and MC) and eligibility samples are drawn from the same universes and are nested within each other. In order for the eligibility sample to be taken across the FFS and MC universes, in practice, the eligibility sample will be divided into an eligibility FFS sample and eligibility MC sample. For each state, the larger of the two samples in a given universe will be drawn first and the second sample will be drawn from the first sample. These will be referred to as the primary and secondary samples.

For example, suppose a given state has a sample size of 500 FFS claims and 300 eligibility reviews from the FFS universe. The 500 FFS claims would be sampled from the FFS universe and the 300 FFS eligibility claims sample would be drawn from the primary, FFS sample. This process is repeated in the MC universe for the MC and eligibility MC samples.

Sample Size for Claims and Capitation Payments

Section 601(f) of CHIPRA required CMS to establish state-specific sample sizes for application of the PERM requirements with respect to CHIP for RYs beginning with the first RY that started on or after the date on which the final rule was in effect for all states, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable: (1) minimize the administrative cost burden on states under Medicaid and CHIP; and (2) maintain state flexibility to manage such programs.

The 2017 final rule established updated state-specific sample size methodology for PERM, although the execution of these responsibilities remains with CMS and the federal contractors, not with the states. Under the Secretary's authority at section 1102(a) of the Act, CMS applied these sampling procedures to both Medicaid and CHIP in order to effectively implement PIIA.

In addition, CMS established a maximum sample size for each state, which is not to exceed 20% of the total cycle sample size. The maximum sample size seeks to reduce individual state burden and sets a limit on the staffing, timing, and monetary requirements needed to complete reviews. Statistical tests suggest that setting a maximum of 2,000 claims per state will not impede achieving cycle precision goals and provides ample information about the state's improper payment rate to discuss the drivers behind the improper payment rate. The maximum of 2,000 claims was based on an analysis of a 10,000 claims sample (9,000 FFS and 1,000 MC), or 20% of the total sample size.

Similarly, the total minimum sample sizes are driven by the minimum sample sizes needed per payment stratum and the estimated sample size necessary for the average state to meet precision requirements. Each state's minimum sample size is at least three percent of the total cycle sample size for each component.

The SC estimates state-specific sample sizes for each program component within each state based on the prior cycle's improper payment rate and the state's expenditures. CMS strives for state-specific precision; however, there is no federal requirement for this level of precision. State improper payment rates are also based on a 95% confidence interval.

FFS Stratification

A dollar-based stratification approach is used for the FFS sample. Each program area is divided into strata based on payment amounts. Five dollar-weighted strata are used for FFS sampling. The total payments in the universe are divided by the number of strata and an equal proportion of payments are included in each stratum. Therefore, each payment stratum for FFS sampling includes 20% of the dollars in the universe. Claims are sorted by payment before being divided into strata, so that a small number of high-dollar payments is placed in the first stratum and a large number of very small payments is in the last stratum.

In addition to the five payment-based strata, FFS has an additional stratum consisting of fixed payments, aggregate payments, Medicare premium payments, and Medicare crossover claims. Generally, this additional stratum is for claims that will not be able to receive MR. The number of lines sampled from this stratum depends on the size of the stratum in comparison to the rest of the universe. There is a cap on the number of claims that can be sampled from this stratum (no more than 10% of the total state sample size). Below is an example of dollar-weighted stratification.

Step 1: The total amount of all payments is divided by five to determine the dollars that need to be allocated into each stratum (20% of expenditures).

Step 2: All lines are sorted from largest to smallest payment amounts.

Step 3: Lines are selected in descending order until there are sufficient lines, added together, to represent 20 percent of total payments. This is the first stratum.

Step 4: The second stratum consists of the next largest lines that represent 20% of total payments.

Step 5: This sequence is repeated until all five strata are constructed.

Step 6: An equal number of lines are then sampled from each of the strata (e.g., if the sample size is 250, then 50 lines are sampled from each stratum).

Note that the first stratum will have the fewest number of claims because each claim will have higher payments, so it takes fewer of them to make up 20% of all universe expenditures. Therefore, this strategy has the additional implication that the sampling frequency in the first stratum, with the high dollar-valued line items, will be greater than the sampling frequency in the last stratum, where very low dollar-line items are included. Explained another way, higher-dollar claims have a greater chance of being sampled, as demonstrated in *Exhibit 6*.

Exhibit 6: Stratification by Expenditures – Five Strata Example

	Stratum 1 (Largest claims)	Stratum 2	Stratum 3	Stratum 4	Stratum 5 (Smallest)	Strata All
Number of lines	18,965	25,099	29,841	83,412	359,476	516,793
Percent of total	4%	5%	6%	16%	70%	100%
Total amount paid	\$4,696,625	\$4,696,748	\$4,696,679	\$4,696,770	\$4,696,719	\$23,483,540
Percent of total	20%	20%	20%	20%	20%	100%
Sample distribution	50	50	50	50	50	250
Sampling frequency	50/18,965 or 1 out of every 379	50/25,099 or 1 out of every 502	50/29,841 or 1 out of every 597	50/83,412 or 1 out of every 1,668	50/359,476 or 1 out of every 7,190	N/A

Enhanced Stratification

Additional strata may be created in PERM universes outside payment-based strata to gain more information about specific claim types. Enhanced stratification methodologies are discussed with CMS ahead of sampling in order to integrate the addition into the sampling design for the cycle.

Managed Care Claims Payment Stratification

The same dollar-based stratification approach is also used for the MC sample. Five dollar-weighted strata are used. There are no additional strata in MC. Denials are rare in MC programs but do occur in some states. Denials have a zero-dollar amount and, therefore, will appear in the stratum with the smallest dollar values.

Sample Selection Process

The general process used to select a sample is summarized in the following steps:

Step 1: Define necessary strata according to the sampling methodology specific to the program and component and sort all lines into the appropriate stratum.

Step 2: Sort all lines in each stratum first by paid amount and then by a random number (the random number is used to order payments with the same dollar amounts).

Step 3: Determine the skip factor for each stratum (k_i). Let N_i be the number of payments in the universe for the i^{th} stratum and n_i be the number of payments in the sample for the i^{th} stratum.

$$k_i = \frac{N_i}{n_i}$$

Step 4: Determine a random start value for each stratum ($start_i$) such that $1 \leq start_i \leq k_i$.

Step 5: Sample every k_i^{th} item within the i^{th} stratum.

Modifications to the Sampling Process

The previous section details the basic sampling process when the universe information is accurate. In practice, problems with the universe data from states are often discovered. If these problems are discovered before sampled claims are sent to the RC and ERC, the sample is redrawn according to the above approach. However, if issues with the original universe are discovered after the RC or ERC have begun reviews, then alternative sampling and estimation approaches must be implemented to maintain the integrity of the sample and accuracy of the final estimate.

Oversamples, also called additional or replacement samples, are determined on a case-by-case basis. However, there are generally two scenarios that warrant an oversample:

- A notable number of claims had to be dropped from an existing sample, so an oversample was necessary to replace the dropped claims.
- A portion of the state's universe was not submitted on time for sampling, or the state unknowingly omitted a portion of the universe.

The size of the oversample depends on the reason for the oversample and the time and resources available for reviewing the oversample. If an oversample is needed to replace dropped claims, usually the number of claims dropped is the number of claims oversampled. The size of the oversample for a missing portion of the universe depends on the quarter in which the issue occurred and the size of the additional universe.

Typically, for missing portions of the universe discovered in Q1-Q3, the additional universe is added to a subsequent quarter and would be processed as part of the regular sample. However, if the issue is discovered in Q4 and reviews have already begun for the last quarter, the missing portion is assigned to a separate stratum and an additional sample is selected to maintain that every claim in the state eligible for PERM review had a chance of being sampled. In both instances, the size of the oversample depends on the size of the additional universe. Usually, the number of claims oversampled is proportional to the state's sample size and current universe size. For example, in a given quarter, if a state's missing universe was 10% of the size of the existing universe in terms of payments, then the state would have an oversample that was 10% of the existing sample size.

However, having a proportional oversample is not always possible. If the missing portion of the universe contained specific types of claims such as fixed payments or denied claims, which were limited in terms of sample size based on the original stratification methodologies, then the oversample would be adjusted to limit the number of additional claims sampled.

Determining the number of oversamples is also dependent on timing and RC or ERC limitations. Since the RC or ERC may not have enough time or resources to review a proportional oversample before the cycle cutoff, the number of claims in the oversample may be capped to

reduce review contractors' and states' burden at the end of the cycle.

Sampling for Eligibility Review

Assuming that the claims samples are larger than the eligibility sample, once claims samples are drawn for DP and MR, the SC then selects a sub-sample of payments to receive eligibility review. In the event that the eligibility sample size is larger than the claims sample size, then there will be payments in the eligibility sample that are not selected for the sub-sample and will only receive eligibility review. This type of sampling allows for one sample to be nested within another, ensuring that a subset of sampled claims will receive all three reviews. The sub-sampling procedure will follow a stratified fractional systematic random sampling design, similar to the primary claims sample for the state.

Exclusions from Eligibility Review Sample

Certain types of claims may not be able to receive eligibility review and must be dropped from the eligibility sample. These include:

- Claims that were denied by the state because no beneficiary information was available on the claim. (note that claims that were denied based upon the state's determination of the case eligibility **are** subject to review).
- Aggregate payments made on behalf of multiple beneficiaries.
- ELE cases where the state relied on a separate program determination on the beneficiary.

V. State Policy Collection Process

In order to perform reviews of state actions that led to payment adjudication, the RC and ERC must have access to and familiarity with state policies. The processes for each contractor are described below.

A. General note on policies related to PHEs

Both the RC and ERC will work with states to collect state policy that outlines any changes to rules or requirements due to extenuating circumstances (e.g., COVID-19 PHE and subsequent Unwinding period). Contractor and state collaboration is essential to a successful PERM review during a complex period of unwinding. The RC and ERC work closely with states during the pre-cycle and review phases to ensure comprehensive understanding of the impacts of unwinding and their applicability to PERM. Intake meetings, pre-cycle webinars, and regular check-in meetings are the primary contractor/state forums for policy and process discussions related to unwinding. States should ensure that the appropriate staff with knowledge about the agenda topics attend and participate in the meetings. States should respond timely to contractor questions and requests for information and/or documentation. States should raise questions or concerns with the appropriate contractor. The contractors will work with states to provide a timely response or resolution.

B. Policy Collection by the RC

The RC is responsible for acquiring Medicaid and/or CHIP policies for each state selected for review for the PERM cycle. The RC collects and stores the state policies and federal regulations in the SMERF system for claims under review during the PERM review cycle. Policies used in the PERM review may include:

- Federal Regulations.
- State policies.
- Manuals/handbooks.*
- Bulletins/updates/notices.*
- Clarifications/reminders.*
- Fee schedules/codes.*
- SPAs/waivers/mitigation plans* (as relevant and approved by CMCS).

*Disclaimer - PERM reviews against official federal regulations and state policies but will take into consideration all other items in the above list as long as they directly tie back to and are not in conflict with a federal regulation and/or state policy.

The RC contacts each state at the beginning of each PERM review cycle. The RC begins the policy collection process by researching state website(s) for all available state policy documents that contain Medicaid and/or CHIP policies relevant to DP review and MR and downloads these from state websites. The RC compiles a MPL of all policies pertinent to the reviews for each state.

After it completes the MPL, the RC sends the MPL to the state for confirmation and approval. The state may provide additional resources that may not be available publicly, including system navigational guides, sample MC contracts, fee schedules, etc. Once the state approves the MPL, the RC saves the document in the SMERF system under the policy tab. The RC continues to monitor and collect state policies throughout the RY, validating the list with the state as appropriate.

The RC uses these policies during the review process to verify the state paid claims according to established requirements. The RC compiles and studies the policies before beginning the DP reviews and MRs. The RC uses state policies and federal regulations to determine the type of documentation generally required to be maintained by each provider type, service coverage and limitation guidelines, payment methodologies, and other associated rules and guidelines each state requires for proper payment of claims.

State Responsibility for Policy Collection

- Provide documents requested for DP reviews and MRs that are not publicly available on the state's websites.
- Complete MR/MRR Policy Questionnaire and provide final approval of the questionnaire to the RC.
- Review and provide final approval of MPL.

C. Policy Collection by the ERC

The ERC obtains all relevant Medicaid and CHIP policies for each state participating in the PERM eligibility review cycle. The process that should be followed to ensure that the ERC has a clear understanding of the state's policies includes research performed by the ERC and state input and provision of policies.

The ERC reviews information from federal regulations as it applies to the various eligibility criteria being reviewed and the eligibility determination process. In addition to the federal policies, which apply to all states in the PERM cycle, the ERC obtains information from each state's regulations and policies. The types of state-specific documents that the ERC should review include:

- Medicaid and CHIP state plans, including all applicable SPAs.
- State statutes.
- State regulations.
- State budget language.*
- State verification plan.
- MAGI policy.
- State non-MAGI policy.
- State CHIP policy.
- Medicaid bulletins.*
- Waivers/Mitigation Plans.*

*Disclaimer - PERM reviews against official federal regulations and state policies but will take into consideration all other items in the above list as long as they directly tie back to and are not in conflict with a federal regulation and/or state policy.

After the ERC has collected and documented the list of relevant policies that were obtained through initial research, the state reviews the ERC's documentation and confirms that all the policies documented are accurate and up to date. If certain policies are not available to the ERC, the state must share them with the ERC in advance of the reviews. In addition, the ERC works with the state to ensure that the policy collection document remains updated throughout the review cycle.

State Responsibility for Policy Collection

- Review Eligibility Policy Survey completed by the ERC for accuracy and completeness.
- Provide policy documents requested for ER reviews that are not publicly available on the state's websites.
- Review and provide concurrence of Eligibility Policy Survey.

VI. MRR Process

The RC is responsible for requesting all medical record documentation associated with the randomly selected Medicaid FFS and CHIP FFS claims. The RC submits the requests directly to the provider's medical record location as verified by the provider. Providers must submit the medical record documentation within 75 days from the date of the letter. The RC will send up to four follow-up letters and make up to four phone calls to each provider during this 75-day

window, as needed, to secure the provider's compliance with open documentation requests. If the provider fails to produce the requested documentation by the 75th day, the RC sends a Final Notice of Non-Response letter via certified mail to the provider and gives a copy to the state PERM representative. The states can use SMERF to track MRRs and a user guide is available on the SMERF homepage, should the state require assistance.

MRR Orientation

The RC schedules educational webinars before it begins requesting medical records from providers to educate states on current MRR processes and to acquire any new state procedures for processing PERM requests.

State PERM Representative Responsibility for RC Educational Webinars:

- Respond to the webinar invitation timely.
- Reserve a conference room and equipment for webinar participants, as needed.
- Invite all appropriate people to the meeting.
- Make copies of all materials or send them to participants in advance.

State Responsibility Prior to Starting MRRs

- Provide completed MRR/MR Policy Questionnaire to RC.
- Review and validate MMIS provider contact information for claims.
- Identify medical documentation management processes followed by fiscal agents and sister agencies.
- Identify special documentation processes or contact information for corporate contacts or multi-hospital systems.
- Provide current contact information for state representatives for inclusion in the RC's records request letters.

A. Provider Contact Validation

By referencing sampled claims, the RC first verifies the provider information by contacting either the performing provider or the billing provider by phone using contact information that the state provides. The RC provides information on the patient, DOS, and type of service and notifies the provider that a written request is forthcoming. The RC verifies the provider's name and phone number as well as the name and mailing address of the person or entity that processes requests for medical records related to the provider's patients. The RC also determines the preferred method for the request (fax or first-class mail). If the RC is unable to verify the provider information on the state's claim files after using other means (e.g., internet, directory assistance), the RC will contact the state to obtain more current provider information.

B. Initial MRR⁶

If the provider prefers to receive record requests via fax, the RC will fax its Initial Request for

⁶ See example of an MRR in [Appendix A](#).

Records to the designated fax number within one hour of designation or as reasonable during high-volume times and resource constraints. If the provider prefers to receive record requests via mail, the RC will send its Initial Request for Records to the POC at the confirmed address via standard USPS first-class delivery within one business day of the telephone contact.

The Initial Request for Records includes a brief introduction to PERM and contact information for RC representatives working to collect medical records. The Initial Request includes language informing the provider that the SC randomly selected a claim submitted by, or on behalf of, the provider for PERM review and indicates that the state may seek recoveries for that claim if the provider does not submit the requested medical records to the RC in a timely manner. The letter describes CMS's authority to collect medical records under the Act and confirms that CMS and its contractors will comply with the Privacy Act and the regulations at [45 CFR § 160](#) and [42 CFR § 164](#). The letter also specifically includes language explaining that the release of medical records and patient information to the RC is not a violation of HIPAA standards. The RC customer service representative's telephone number and the provider's state Medicaid representative's telephone number are included if the provider requires additional information or has questions.

The Initial Request for Records includes a claim summary with details for the provider to identify the appropriate record, such as:

- The patient's name.
- DOS.
- Diagnostic code (International Classification of Diseases [ICD], Tenth Revision, Clinical Modification [ICD-10-CM]).
- Service code (CPT, Healthcare Common Procedure Coding System [HCPCS] or prescription number).
- Total amount of claim or total amount for service.

The Initial Request for Records package also includes a PERM Cover Sheet that describes the specific documentation being requested (a request list is attached to the Initial Request letter) and asks that the provider send the RC all medical documentation pertaining to the specific service rendered. Prior to sending the initial record request, the RC assigns each claim to a specific claim category. Each claim category has its own list of unique but standard documentation (e.g., history and physical, plan of care, physicians' orders) that is typically required to support claims assigned to each respective category. Finally, the letter indicates that the provider has 75 calendar days from the issue date of the letter to provide the requested medical record(s) to the RC. The last enclosure of the package includes instructions for providers' submission of medical records to the RC. Providers submit records to the RC via the USPS, a toll-free fax number, Compact Disc, or esMD. For more information about esMD, see www.cms.gov/esMD.

State Assistance with Obtaining Medical Records from Providers

The state is encouraged to work closely with the RC to obtain medical records from providers. The RC provides claim information and tracks provider responses to requests via the SMERF

system. The states use the SMERF system to track RC MRRs and to monitor provider responsiveness to those requests. The RC provides states with copies of MRR letters sent to providers each week on Friday via the RC's SFTP. The RC Records Manager collaborates and coordinates MRRs with states to ensure timely processing of MRRs. Based on the information from SMERF, email notices, and communication with the RC Records Manager, the states must closely engage providers to ensure the RC receives all requested medical records before the 75-day due date or cycle cutoff date, at the very latest.

State Best Practices for Obtaining Medical Records from Providers

- Send letters to each provider sampled for MR; a template for State Education to Sampled Providers is available for states in SMERF under the State Educational Resources.
- Post information to the state Medicaid/CHIP websites about the upcoming PERM audit or send a notice through the state's email listserv.
- Provide the RC with updated contact information on providers if applicable.
- Identify a contact person for corporate medical organizations, school systems, and state fiscal agents, agencies, and sister agencies.
- Develop Integrity Teams to help locate and contact providers.
- Review and edit contact information in the state MMIS early in the cycle for PERM+ states and ensure current provider contact information is provided to the SC during the details file process for Routine PERM states.
- Monitor the status of MRRs via the SMERF system.

State Responsibility during MRR Process

- Monitor and track MRRs via SMERF.
- Collaborate and communicate with the RC about MRRs.
- Respond to RC requests for assistance with provider contact information.
- Contact providers about responding to MRR requests.

C. Follow-Up MRR

The RC contacts each provider that has not submitted the requested records by telephone. The RC will make up to three follow-up calls at 30, 45, and 60 calendar days from the Initial Request and will send up to three follow-up letters that remind the provider of the date on which the 75-day clock will expire.

If the provider does not submit the requested information by the deadline, the RC sends a final letter that contains the detailed request information. The letter also informs the provider that his or her failure to submit the requested medical records resulted in a PERM error and that the RC will notify state officials of the error, possibly causing the state to seek recoveries for the claims related to those absent medical records.

D. Follow-Up for Incomplete Documentation

The RC will process additional documentation requests when the RC receives incomplete documentation from the provider. Once a medical reviewer identifies that the documentation

for a specific service is incomplete, he or she will note specifically what documentation is necessary to complete the review. When documentation submitted by providers is incomplete, the RC calls the providers and sends them a Request for Additional Documentation letter in an effort to secure the additional documents needed. Providers have 14 calendar days from the date of the letter to submit additional documentation. If the RC does not receive the additional documentation requested within seven calendar days from the provider, the RC makes a reminder call to the provider and sends a reminder letter. If the RC does not receive the additional documentation from the provider within 14 calendar days, the RC will cite it as a Document(s) Absent from the Record (MR2) error.

If the provider does not submit the requested information by the deadline, the RC will send a Final Notice of Non-Response to Request for Additional Documentation letter to the provider via certified mail and provide a copy of the letter to the state PERM representative via the RC's SFTP. The letter also informs the provider that his or her failure to submit the requested medical records resulted in a PERM error and that the RC will notify state officials of the error, possibly causing the state to seek recoveries for the claims related to those absent medical records.

If the provider responds to the additional documentation request but the submission is still incomplete, the RC will inform the provider via telephone that the documentation remains incomplete. The RC then sends a Receipt of Incomplete Information letter to the provider requesting that the provider submit the specific missing documentation.

E. Resubmission Documentation Requests

The RC will send out Resubmission Documentation Request letters to providers when it identifies one or more of the following issues:

- Illegible copies of the medical record documents.
- Incorrect dates of service submitted.
- Medical record documentation submitted for the wrong patient.
- No medical record documentation submitted with PERM Cover Sheet.
- No beneficiary name and date of birth on medical record documents.
- Incomplete fax received (e.g., the RC receives only four pages of a 30-page submission).

F. Late Documentation Policy

In cases where the RC receives no documentation from the provider after 75 days have passed since the Initial Request, the RC considers the case to be a No Reviewable Documentation Received Error (MR1). If the RC determines that the documentation the provider submits is not complete enough to determine whether the state correctly paid the claim, it will request additional documentation from the provider. Providers have 14 calendar days to submit the additional documentation to the RC. The RC will also consider any documentation received after the final day as late documentation.

If the RC receives late documentation before the cycle-cutoff date, for improper payment rate calculation and reporting purposes, it will review the records and, if appropriate, revise the error

finding. This means that providers may still submit new and supplemental documentation for review until the end of the cycle even if the RC has cited the claim as an MR1 or MR2 error because the provider failed to respond to the request for records or only submitted incomplete or insufficient documentation. Providers may submit this documentation through the cycle cutoff date even if the state's DR/appeals timeframes have expired. State assistance in collecting these late records is essential in reducing documentation error findings. State follow-up with providers to attempt to obtain records for review should continue even after the 75-day and 14-day due dates have passed.

If the RC receives documentation after the cycle cutoff date, the RC will review the documentation only if the request qualifies (still within the 75-day timeframe for original requests or within the 14-day timeframe for additional documentation requests).

G. Policy for Handling Lost or Destroyed Documentation

PERM involves reviewing medical documentation in support of paid FFS claims in both the Medicaid program and CHIP. The RC contacts providers and asks them to submit documentation for review of their claims. A provider may be unable to provide documentation due to its loss or destruction from a natural disaster such as a flood, hurricane, earthquake, or tornado, and in cases of destruction by fire. In the event of a FEMA-declared disaster, the SC will drop the MR of the claim from the sample and replace the claim with another randomly sampled claim if time allows. The RC will work with CMS to make a determination of whether or not a case will be dropped in the event of a fire on a case-by-case basis.

Provider Attestation

If a provider is unable to supply the documentation due to loss or destruction from a disaster, the provider should submit an attestation statement with the PERM Fax Coversheet using any of the information submission methods described in the [Initial MRR](#) section of this document to the RC within 75 days of the date of the initial written request for documentation from the RC.

Re-Sampling or Excluding Claims

In the event that a provider's documentation has been lost or destroyed in a FEMA-declared disaster, the SC will replace the sampled claim with another randomly sampled claim from that state's universe for the PERM review. In the event re-sampling is no longer possible due to timeline constraints, the SC will remove the claim(s) from the sample.

H. Policy for Providers Under Fraud Investigation

States may choose to suppress medical record/documentation requests and MR for specific providers/claims to avoid interfering with or impeding active fraud investigations. If the provider is under investigation for potential fraud and the state does not want PERM contractors to contact the provider to request medical records, the states may suppress the claim from PERM MR.

States will notify the SC during the details process of any providers that should be suppressed from review for reason of fraud investigation. The state may notify the SC of the applicable PERM IDs, and the SC will apply the fraud suppression at the PERM ID level. States may also supply information to the SC at the provider level by notifying the SC of the applicable state provider National Provider Identifier (NPI). If states provide information to the SC at the provider level, the SC will then apply the suppression at the PERM ID level. States must notify the SC each quarter of any sampled claims or providers that should be suppressed from MR since the status can change during the cycle. Once implemented, a fraud suppression remains in effect throughout the PERM cycle unless the state indicates otherwise by notifying the SC of the change.

If a state identifies claims after reviews have begun that should have a fraud suppression, please notify the SC as soon as this is discovered. If a state should want fraud suppressed claims reviewed at a later date because the provider/claims are no longer under active fraud investigation or because the state does not want the cases to be cited as MR1 errors, then it must inform the SC as soon as the change in status is identified but no later than the cycle cutoff date. Depending on the timing of the change, the state and RC will work together to determine next steps. If the change occurs towards the end of the cycle, the state may be responsible for obtaining and submitting the required documents.

PERM does not drop these types of claims from the sample. PIIA requires federal agencies to measure “improper payments” and does not distinguish between different types of improper payments (for example, errors versus fraud). Since the provider cannot submit the record for review, the RC will find a No Reviewable Documentation Received Error (MR1) and will report the claim as an error in the final findings. Errors cited for providers under fraud investigation will appear in the state’s FEFR report and CAP as MR1 (No Reviewable Documentation Received) errors. For these findings, the state may include “provider(s) under fraud investigation” as the corrective action taken by the state to address the error. These instructions will be included as a footnote in the report.

VII. MR

The MR determines the appropriateness of the service provided and whether the documentation supports the service. The RC reviews the provider’s medical record or other documentation supporting the service(s) claimed. Service requirements may include a state’s documented policies, federal regulations, and any other contractual or legal requirement that is a contingency of providing the service under review.

MR error findings include, but are not limited to:

- No reviewable documentation received.
- Documentation absent from record.
- Procedure code incorrect.
- Diagnosis code/DRG incorrect.
- Unbundling codes from a group code and billing individual services.

- Number of units incorrect.
- Medically unnecessary service.
- Other policy violation.
- Inadequately completed documentation.
- Administrative/other.

The RC conducts MR on all sampled FFS claims, with the exception of Medicare Part A and Part B premiums, PCCM payments, aggregate payments, other PERM fixed payments, denied claims, and zero-paid claims. MR may be required for denied claims if the state denied the claim for medical necessity or for other reasons verifiable only through MR. MR is separate from the DP review. States can track MR findings using SMERF. Although in most cases the RC will review individual line items, it may be necessary to review all items on a claim in order to determine the accuracy of the individual line. Reviewers will not record errors associated with lines on a claim that were not part of the sample.

A. Basic MR Components

The mechanics of the MR (e.g., requested documentation, reviewed policies) vary by service type. In general, review procedures will map closely to the PERM claim categories; although, in some cases, specific review procedures may be required due to state policy or for specific services. See the PERM claim categories for MR and DP below.

Claim Category 1: Inpatient Hospital Services

- Acute inpatient.
- Long-term acute.
- Acute inpatient rehabilitation.
- Opioid treatment programs.

Claim Category 2: Psychiatric, Mental Health, and Behavioral Health Services

- Inpatient and outpatient psychological, psychiatric, and behavioral health services.
- Drug and alcohol inpatient and outpatient services.
- Group homes.
- Opioid treatment programs.

Claim Category 3: Nursing Facilities, Chronic Care Services, or ICFs

- Nursing home and convalescent centers.
- Chronic care.

Claim Category 4: ICFs for Individuals with Intellectual Disabilities and ICF/Group Homes

Claim Category 5: Clinic Services

- Hospital-based clinics.
- FQHCs.
- IHS.
- RHCs.
- Opioid treatment programs.

Claim Category 6: Physicians and Other Licensed Practitioners Services (Includes: Advanced Practice Nurse, Physician Assistant, Nurse Midwife, and Midwife)

Claim Category 7: Dental and Oral Surgery Services

Claim Category 8: Prescribed Drugs

Claim Category 9: Home Health Services

- Home health agency services and medical supplies.
- Equipment and Appliances through the agency.

Claim Category 10: Personal Support Services

- Personal care services (qualified service provider, personal care attendant, aide [certified nursing assistant], homemaker services, and respite care).
- Case management/targeted case management services.
- Private duty nursing.
- Meal delivery services.

Claim Category 11: Hospice Services

- Services provided at home or in a nursing facility, hospital, or hospice facility.

Claim Category 12: Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology, and Rehabilitation Services; Ophthalmology, Optometry, and Optical Services; Necessary Supplies and Equipment

Claim Category 13: Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs and School-Based Services

Claim Category 14: Laboratory, X-Ray, and Imaging Services

Claim Category 15: Outpatient Hospital Services

- Outpatient services.
- Emergency services.

Claim Category 16: DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications

Claim Category 17: Transportation and Accommodations

The following claim categories do not require MR:

Claim Category 18: Denied Claims

Claim Category 19: Crossover Claims

Claim Category 30: Capitated Care/Fixed Payments

- Fixed payments for PCCM.

- Medicare Part A premiums.
- Medicare Part B premiums.
- HIPP.
- Aggregate payments.

Claim Category 50: Managed Care

- Capitated payments to a Health Maintenance Organization, Health Insuring Organization, or PACE plan.
- Capitated payments to Prepaid Health Plans.

Claim Category 99: Unknown

- Sampler file has been loaded but details file has not been loaded. This is a temporary claim category assignment.

B. Process for Conducting the MR

The RC conducts a comprehensive MR on each sampled unit (entire claim or line item) for which it receives medical records. This includes reviewing medical record documentation, federal regulations, and state-specific policies related to the claim to determine whether the service was medically necessary, reasonable, provided in the appropriate setting, billed correctly, and coded accurately.

All FFS claims sampled for review have a nurse review for medical necessity and/or reasonableness and to determine if the provider provided care in the appropriate setting, in accordance with federal regulations and state policy. All FFS claims also have an independent coding review to validate accuracy of diagnosis codes, DRG codes, procedure codes, and the number of units billed.

The RC reviews claims for medical errors according to federal regulations and state-specific policies (e.g., if a certain aspect of the recommended review process outlined does not apply in a given state, such as state system limitations requiring billing of local codes instead of national codes, reviewers do not need to follow that aspect when reviewing that state's claims if it is not in conflict with the federal regulations). The reviewer is responsible for using all applicable documents, references, medical necessity guidelines, and his or her clinical review judgment to determine if the service was medically necessary and paid according to required policies.

Verification of Documentation Sufficiency

The RC determines whether the submitted documentation is appropriate and sufficient to complete the MR by evaluating if:

- The documentation received supports the service billed.
- The documentation supports the requested sampling unit.
- The documentation supports the DOS.
- The documentation includes signed physician orders.
- The documentation includes approved certifications/re-certifications required by state policy.

The original MRR lists the specific supporting documentation that providers should send for each claim category.

Verification of Service Provision in Accordance with State Policy

The policy review includes review of the applicable state-specific Medicaid or CHIP policy related to the service on the claim. The procedure or service documented in the medical record is reviewed to determine if the service was covered under the state's policy, if there were any applicable limitations (e.g., units, quantities), and if the provider's service fell within those limitations. Source documentation for the review will include documented state policies, including non-covered benefit limitations, provider manuals, and the CFR.

Confirmation of Medical Necessity of Service

The medical necessity review includes review of the record to determine if the service provided was consistent with the symptoms or diagnosis under treatment. In addition, the review may also involve a contextual claim review of other services provided to determine the pattern and feasibility of the sampled service. This may include an entire MR to determine if the sampled service was medically necessary.

Source documentation includes documented state policies, including medical necessity documentation guidelines the state used, provider manuals, and the CFR.

Determination that the Service Rendered Matches the Service Codes Billed and Paid

The coding validation involves confirming the diagnosis recorded by the provider and its relevance to the billed procedure code. The coding review includes reading the medical record documentation and applying applicable ICD-10 coding guidelines to ensure the code the provider billed and the payer paid is the most appropriate code and level of code for the service rendered and that the provider did not assign multiple codes when only one code is appropriate (unbundling).

For the RC to determine whether it received appropriate and sufficient documentation, it evaluates if:

- The medical record documentation is consistent with the code billed by the provider.
- The procedure codes are unbundled.
- The billed code is consistent with the provider's diagnosis.
- The diagnosis code is appropriate (if relevant to the payment).
- The diagnosis is included in the DRG (if relevant to the payment).
- Another procedure code would be more appropriate.

Verification of Appropriate Physician Certification

For long-term care, inpatient hospital services, ICF, and home health care, the review verifies the documentation contained a signed physician certification, if required by state policy.

Preparation and State Responsibilities

State Responsibility Prior to Starting MRs

- Ensure everyone within the state team knows what their roles and responsibilities are with regard to PERM at the beginning of the cycle. Make sure fiscal agents have dedicated staff to support PERM. States may choose to prepare a timeline of PERM activities for distribution to internal staff prior to the beginning of MRR and MR for state staff to use as reference and to track the timeline closely throughout the review phase.
- Participate in RC check-in and MR/MRR orientation calls before the review cycle and include state representatives from the areas of state programs, policies, payment calculations, and adjudication systems, etc., as appropriate.
- Provide complete responses to the RC's MR/MRR Policy Questionnaire, including appropriate supporting documentation and links to state policies.
- Verify that the RC's draft MPL is complete and accurate by the date requested by the PERM RC. During the state's review of the draft, add relevant policy information and correct inaccurate information. Review and finalization of the draft MPL usually occurs in January/February of the second year of the cycle. Assist the RC with accessing state policies.

State Responsibility during MRs

- Participate in check-in calls during the review cycle and include state representatives from the areas of state programs, policies, payment calculations, and adjudication systems, etc., as appropriate.
- Review, resolve, and address improper payment findings as they appear on the SUD report. The SUD report is released on the 15th and 30th of each month. After the release of each SUD, the RC will send copies of medical records to the state for all MR errors that are included on the SUD.
- Track errors and request DR within 25 business days after findings posted to SUD and/or request appeals within 15 business days after the DR decision date for disputes of finding. Business days exclude weekends and federal holidays.
- Submit repricing requests to the RC for partial MR errors. See [Repricing a Partial Error](#) section for more information.
- Submit applicable documentation via Kiteworks to support responses to questions, MR repricing requests, and DRs. Refer to the PERM RC Fast Facts flyer *RC Secure File Transfer via Kiteworks* for information on using and requesting access to Kiteworks. See section [Sending Documentation to the RC via SFTP](#) for more information.
- Communicate findings to state Medicaid and CHIP leadership.

C. Special Rules for MR

Partial Errors

An error is considered partial when a portion of the payment that was made is incorrect. For example, the provider billed and was paid for ten units of service, but the documentation only supports that five units of service were provided. In this scenario, the full amount of the original payment is cited in error; however, a portion of the payment (five units of service) was correct. MR errors that may result in a partial error include the following:

- *MR3: Procedure Coding Error.*
- *MR4: Diagnosis Coding/DRG Error.*

- *MR5: Unbundling Error.*
- *MR6: Number of Unit(s) Error.*
- *MR7: Medically Unnecessary Service Error.*
- *MR10: Administrative/Other Error.*

This list is not all inclusive, but it represents the most common error codes resulting in MR partial errors. Depending on the finding, other errors may also result in a partial error.

Repricing a Partial Error

If the MR indicates that an MR error should be cited, but the claim or line item needs repricing, the RC first determines the error amount to be 100% of the total value of a sampling unit (i.e., the amount of money paid for the service that the RC reviewed).

The state is encouraged to request repricing of claims cited with a partial error but for which the error amount reflects 100% of the total. The state must provide written documentation to the RC verifying the accuracy of the repricing for the RC to consider a finding for repricing. States must submit written evidence, such as screen prints, fee schedules, or other valid sources to support the repriced amount. The documentation the RC needs does not have to be based on an actual adjustment to the provider. The supporting documentation the RC needs is the “what if” evidence of how the system would have processed the claim if it had been billed correctly. States must also include the payment calculation. States can utilize the DR process to formally request repricing or submit a request for repricing to the RC via email and submit appropriate documentation before cycle cutoff. States are advised to also include their CMS PERM State Liaison on these informal email requests. If the state does not provide the information necessary to reprice the claim by the cycle cutoff, the claim will remain a 100% improper payment. Please refer to the [Repricing MR Partial Errors during DR](#) section for more information on repricing MR errors.

DOS

If reviewers note a discrepancy in the DOS billed and the DOS in the medical record:

The RC will cite an error if there is a policy that requires the DOS in the record to match the DOS on the claim.

If no policy exists, the RC will alert the state of any discrepancies between the DOS in the medical record and the DOS on the claim as an observation.

D. Sending Documentation to the RC via SFTP

When sending documentation to the RC, states should use the RC’s SFTP site, Kiteworks. Email should never be used to transmit documents that potentially contain PII and/or PHI. Any time the state provides documentation to the RC to support a MR, the documentation should be sent through the SFTP. Occasionally, the RC will use the SFTP to send case or system information to the state to facilitate policy and process questions. The RC may also send system access forms to the state via SFTP if the forms contain PII or may send large files that cannot be sent via

email.

The state may choose to have multiple users establish access to the RC's SFTP. Users can establish accounts at any point during the cycle, but it is recommended states establish accounts before the review phase begins for the state's current cycle to troubleshoot any access issues. Sharing SFTP accounts is strictly prohibited and will result in deactivation of the account.

The RC will send instructions to states at the beginning of the cycle to: help states register, send, and retrieve secure packages; change an SFTP password; and find support if needed. The instructions contain directions and screenshots to address all steps in the process. If at any time a state representative needs support or has questions regarding the RC SFTP, they should reach out to a member of the RC PERM team via email. The State User Educational Resources page under Tools within SMERF contains a detailed guide for the RC's SFTP.

E. MR Error Codes⁷

MR1–No Reviewable Documentation Received Error: The provider failed to respond to requests for the medical records or the provider responded that he or she did not have the requested documentation, or the provider did not send any documentation related to the sampled payment. (i.e., wrong date of service, wrong beneficiary).

MR2–Document(s) Absent from Record Error: The submitted medical documentation is missing required documents, making the record insufficient to support payment for the services billed. The provider submitted some documentation, but the documentation is inconclusive to support the billed service.

MR3–Procedure Coding Error: The medical service, treatment, and/or equipment was medically necessary and was provided at the proper level of care but was billed and paid based on a wrong procedure code.

MR4–Diagnosis Coding/DRG Error: According to the medical record, the principal diagnosis code was incorrect or the payer paid for an incorrect DRG, resulting in a payment error.

MR5–Unbundling Error: A set of medical services was provided and billed as separate services when a CMS regulation, policy, or local practice dictates that the services should have been billed as a set.

MR6–Number of Unit(s) Error: The number of units billed by the provider were not supported in the record documentation.

MR7–Medically Unnecessary Service Error: There is sufficient documentation in the records for the reviewer to make an informed decision that the medical services or products were not medically necessary.

⁷ Error codes are used to group findings at a high level and are subject to change from cycle to cycle.

MR8–Policy Violation Error: The billed service or procedure did not comply with a documented policy that applied to the service or procedure at the time it was performed and/or billed.

MR9–Improperly Completed Documentation Error: The required forms and documents are present in the record, but inadequately completed to verify that the services were provided in accordance with applicable policy or regulation.

MR10–Administrative/Other Error: MR determined a payment error, but the error does not fit into one of the other MR error categories.

MTD–Medical Technical Deficiency: This error code is no longer in use and has been retired.

VIII. DP Reviews

The RC conducts DP reviews on each sampled FFS and MC payment to validate the state processed the claim correctly based on information found in the state’s claim processing system and other supporting documentation maintained by the state. The DP review determines whether a claim was paid to an eligible provider, on the basis of having met certain claims requirements, for a paid amount that was accurately calculated and loaded in the system, and in agreement with certain data elements in the claims payment and eligibility systems. The RC reviews data housed in the claims processing system, claim submissions, and any documentation or system supporting that the claim was processed appropriately. Payment requirements include a state’s documented policies, federal regulations, and any other contractual or legal requirement that is a contingency of processing the claim payment under review. The DP review does not measure for medical necessity or beneficiary eligibility. Claims not processed through a state’s MMIS are subject to validation through a paper audit trail, state summary, or other proof of payment.

A DP error is a payment error resulting in an overpayment or underpayment that the state’s MMIS or other payment systems could have prevented. The difference in payment between what the state paid and what the state should have paid is the dollar amount of the payment error.

DP errors include, but are not limited to:

- Payments made in duplicate.
- Payments for non-covered services.
- Payments of FFS claims for which there was MC coverage.
- MMIS system errors.
- Payments for services that should have been paid by a third party.
- Pricing errors.
- MC rate cell errors.
- MC payment errors.
- Provider information/enrollment errors.
- Submission timeliness errors.
- Administrative errors.

All FFS and MC claims are eligible for DP review. For FFS claims sampled at the header level, the DP review includes examining all line items in each claim to validate the state processed it correctly. For FFS claims sampled at the line level, the DP review includes examining the payment for the line sampled. DP reviews of MC payments examine whether the state accurately processed the sampled capitation payments.

Before DP reviews commence, the RC asks the state for copies of all claims processing manuals, waivers, state policies, system navigational tools, and pricing guides. The RC may gather supplemental DP review tools during reviews as it identifies additional needs or processing exceptions. States can track DP findings using SMERF.

A. Basic FFS DP Review Components

The RC reviews the following elements during DP reviews of FFS claims.

Verification of Beneficiary Information

To determine that the beneficiary was eligible for payment of the services under review, the RC reviews the accuracy of the claims processing system for beneficiary information, including:

- Date of birth/age.
- Date of death.
- Citizenship status.
- City/zip code if needed to determine MC status.
- County of residence if needed.
- Gender.
- Beneficiary ID.
- Living arrangements (home vs. institutional setting).
- Patient liability.
- Patient LOC, if applicable.
- Aid category/benefit plan.
- Effective dates of eligibility.
- Beneficiary residency or population requirement for enrolling in a MC plan or living in a mandatory MC geographical area.
- Incarceration status.

Note that the purpose of beneficiary DP review is to determine whether the information in the financial system is accurate and if the claim paid appropriately according to that information. This review does not include an evaluation of whether a beneficiary's eligibility determination is accurate, but only whether the determination was accurately reflected in the financial system.

Verification of TPL Information

The RC reviews TPL and Medicare information to determine whether another benefit source was available for the service and, if so, whether the state considered the benefit in accordance with the state's TPL policy (cost avoidance, pay and chase). TPL information review includes:

- Medicare eligibility – Parts, A, B, and D with dates of eligibility.
- Other TPL information including coverage dates and covered services.

Verification of Provider Enrollment

In order to verify that the provider(s) (including billing, ordering/referring, and, when appropriate, attending/rendering) were enrolled and eligible to provide and bill for the services under review, the RC reviews:

- Provider name.
- Provider NPI.
- Provider enrollment.
- Provider license, if required.
- Clinical Laboratory Improvement Amendments (CLIA) certification, if required.
- Provider type.
- Provider service location.
- Provider federal sanction/suspension periods, including verifying a provider is not listed on the OIG List of Excluded Individuals/Entities.
- State compliance with RBS for providers.

Independent Verification (IV) of DP Reviews

For claims where sufficient documentation of provider RBS is not provided, the RC works within state and other systems to independently verify whether the providers would have passed the database checks as an additional step in the review process. The RC performs this verification independently, without any required state assistance or support. IV by the RC helps inform future considerations as it relates to the improper payment definitions for PERM and can also help give states a better understanding of their errors.

While any IV findings will not change the actual finding of the PERM review, the RC and CMS will categorize these findings as technically improper for OMB reporting purposes when the RC can independently verify that the provider would have passed the database checks, making them eligible to provide and bill for the services under review. Technically Improper Payment is defined within Appendix C of the OMB A-123 Circular as, “A payment made to an otherwise qualified recipient for the right amount, but the payment failed to meet all regulatory and/or statutory requirements.” A technically improper payment is a non-monetary loss type of improper payment. Technically improper payment errors will not be included in each state’s FEFR report and will not be required to be recovered. For any findings cited as “technically improper,” the state is not required to recover the overpayment funds or return to CMS the federal share of the identified overpayments. An overpayment may still be assessed and included on the FEFR for recovery if an MR error and/or another DP error also exists on the claim.

DP reviews completed with the assistance of IV will be considered technically improper payments. An example is when a state fails to perform or document RBS database checks when enrolling a provider and where the RC is able to independently verify that the provider would have passed screening using the same data available to the state at the time of enrollment. Since the state did not complete and/or document the enrollment RBS checks, an improper payment will remain on all state-specific findings documents, but the RC will categorize the IV finding as technically improper for OMB reporting.

IV results will be provided to CMS and states at the end of the cycle. IV attempts to gain more information about insufficient documentation payment errors. If more information is known about this group of improper payments, CMS can further evaluate the definition of an improper payment. Although the official improper payment rate will include insufficient documentation payment errors, the RC will document provider database checks that can be independently verified during the cycle, separately record review findings (if applicable) that result from IV, and provide that information to CMS and states.

Verification of Accurate Claim Payment

To determine that the payment for a covered service was accurately calculated and paid, the RC reviews:

- The claim filing date and filing timelines applicable to that claim/provider type.
- If the service was covered by the program (Medicaid or CHIP) that paid the claim.
- If the service required prior authorization for payment of the claim.
- Documentation demonstrating the appropriate payment calculation methodology and documentation to support the accuracy of each element of the payment calculation in effect for the DOS, which may include:
 - Fee schedules:
 - Applicable copays or fees for a service.
 - Discounted rates for providers.
 - Price reporting elements that form the basis for payment amounts (e.g., Average Wholesale Price [AWP], Wholesale Acquisition Cost [WAC]).
 - Duplicate payment history.
 - Adjustments to the sampled claim.

In order to complete these aspects of the review, the reviewer may need access to screens containing information on National Drug Codes (NDCs), revenue codes, procedure codes, payment rates, pricing schedules (e.g., DRG, per diem, max fee, provider-specific), and pricing methodologies for all types of claims. If the state makes retroactive rate adjustments, the reviewer must access the rates that were in effect for the DOS on the date that the claim under review was paid. Information about how the state calculates each type of payment may be required. If the state processes payments for “sister agencies” that receive pass-through FFP at the federal match rate (e.g., Medicaid in public schools, mental health), this information must be identified so the reviewer can accurately determine pricing methodology. The reviewer may need access to other claims in the system to conduct a check for duplicates. If the provider filed a hard copy claim, access to the scanned image of the claim, as well as the system information, is required. Finally, the reviewer may need access to tables that explain codes used in the system (if this is not contained in the system).

B. Basic MC DP Review Components

In order for the RC to determine that the beneficiary was eligible for the capitation payment and that the capitation payment was processed correctly, the RC: verifies beneficiary information (beneficiary elements verified are the same as the FFS DP review); reviews health plan/MCO contracts; verifies health plan enrollment; and verifies correct payment.

Verification of Beneficiary Information

To determine that the beneficiary was eligible for payment of the services under review, the RC reviews the accuracy of the claims processing system for beneficiary information, including:

- Date of birth/age.
- Date of death.
- Citizenship status.
- City/zip code if needed to determine MC status.
- County of residence if needed.
- Gender.
- Beneficiary ID.
- Living arrangements (home vs. institutional setting).
- Patient liability.
- Patient LOC documentation (only reviewed when LOC relates to MC payment).
- Aid category/benefit plan.
- Effective dates of eligibility.
- Beneficiary residency or population requirement for enrolling in a MC plan or living in a mandatory MC geographical area.
- Incarceration status.

Note that the purpose of beneficiary DP review is to determine whether the information in the financial system is accurate and if the claim paid appropriately according to that information. This review does not include an evaluation of whether a beneficiary's eligibility determination is accurate, but only whether the determination was accurately reflected in the financial system.

Health Plan/MCO Contracts

To establish that the capitation paid was correct, the RC reviews the terms of the health plan/MCO contract to determine:

- Capitation rates in effect for coverage month.
- Partial month coverage/recoupment policy.
- Population and service carve-outs.
- Geographic service areas covered by each plan under contract.
- Other contract terms that could affect proper payment.

Verification of Health Plan Enrollment

The RC also verifies the following health plan enrollment information:

- Health Plan name.
- Health Plan number.
- Health Plan enrollment.

Correct Payment

The RC determines whether the beneficiary was in the correct rate cell/category based on state policies and the health plan contract, and whether the state made proper payment based on that rate cell/category.

The RC checks for duplicate payments made for the same beneficiary for the same month and documents any adjustments made within 30 days prior and 60 days after the sampled payment date.

C. DP Review Preparation and State Support

DP Webinars

The RC schedules a DP Webinar with each state before the PERM DP reviews commence. The RC holds this Orientation Meeting/Introductory Webinar early in the cycle to begin facilitating DP reviewer access to state systems. Orientation Meetings/Introductory Webinars can last one to two hours, depending on whether the RC needs to conduct reviews of multiple state and/or vendor systems. States with multiple systems of record may need more time for the orientation. In addition, states that have a separate fiscal agent or system for their CHIP may need additional time for the orientation.

At a minimum, the following state personnel should attend these DP Webinars:

- PERM coordinator.
- Claims manager(s).
- Individuals involved in determining whether to file a DR request or Appeal for errors cited.
- Individuals who pulled and sent data for the universe.
- The waiver program representative.
- The CHIP representative.
- Representative for any other special programs for your state.

Agenda items for the DP Webinars include:

- Introductions.
- Review the state system(s) questionnaires, DP questionnaires, and RBS Assessments (completed before the meeting by the state).
- Discuss remote reviews, including requirements for access (system training, virtual private network [VPN], or web access, etc.).
- Establish tentative dates to begin reviews, determine number of review staff, and what needs to be accomplished before starting reviews (establish log-on and passwords, systems forms, etc.).
- Review any special programs (waivers, etc.).
- Review state processes for documenting provider enrollment and RBS results.
- Discuss any new systems (as needed).
- Determine and gather desk aids, manuals, and website links needed for training DP reviewers.
- Review state DP Remote Review Checklist for a clear understanding of requirements to conduct DP reviews.
- Meeting review and reiterate next steps.

State PERM Coordinator Responsibility for the DP Webinar

- Respond to the RC request for state availability (date/time) to hold the DP Webinar timely.
- Invite all appropriate people to the meeting.

- Distribute copies of all materials (e.g., completed state questionnaires) to state participants in advance.
- Complete and return the systems questionnaire(s) prior to the meeting.

Preparation and State Responsibilities

The RC and the state perform the following preparation activities prior to the start of DP reviews:

- The state supplies systems access forms, confidentiality forms, Data Use Agreements (DUAs), or other required documents for the assigned DP reviewers or RC to complete; the documents required vary from state-to-state depending on each state's systems security requirements.
- The RC schedules a conference call between the state's IT personnel and the RC's IT personnel as needed to facilitate remote reviewer access to the state's MMIS.
- The state PERM coordinator and the lead DP reviewer work together to ensure all necessary arrangements are in place before the reviews start.
- Before the reviews start, the RC creates desk aids (from materials gathered during the webinar and from state websites) for SMERF that all DP reviewers assigned to the state review can access.

State Responsibility Prior to Starting DP Reviews

- Provide the lead DP reviewer with all information requested at the DP Webinar at least two weeks before reviews begin.
- Collect and submit all forms required to provide the RC's reviewers with system access, and create login accounts and passwords for the reviewers in advance so the reviewers can start their reviews timely; this applies to all systems the reviewers will need to access, including MMIS, imaging, or other systems such as dental or pharmacy if claims are not in MMIS.
- Submit the signed state DP Remote Review Checklist to the RC's lead reviewer to confirm the state's readiness to begin DP reviews.
- Make sure state and RC IT staff have worked together to establish systems access in time to start reviews as planned and establish a help desk contact for access and password issues.

State Responsibility during Remote Reviews

- Make sure SMEs respond timely to pending issues throughout the review.
- Work with the lead RC reviewer to determine dates and times for exit conferences.
- Timely resolve systems access issues.

State Responsibility Throughout the Cycle Period

- Participate in check-in calls during the review cycle and include state representatives from the areas of state programs, policies, payment calculations, and adjudication systems, etc., as appropriate.
- Monitor the P1 (Pending/Notification) list in SMERF.
 - The RC places PERM IDs on this list when it determines, during a DP review, that additional information is required to complete the review.
 - The P1 list is available in real-time via the state portal in SMERF. States are

encouraged to provide the information requested within 14 calendar days so that PERM IDs can be removed from the P1 list and reviews can be completed.

- Once a claim appears on the P1 list, states are given 14 calendar days, beginning the Friday of the week of posting, to respond to an information or documentation request. If the state does not respond to a claim on the P1 list within 14 calendar days, the RC will cite an error.
- Review, resolve, and address improper payment findings as they appear on the SUD report. The SUD report is released on the 15th and 30th of each month.
- Track errors and request DR within 25 business days after findings posted to SUD and/or request appeals within 15 business days after the DR decision date for disputes of finding. Business days exclude weekends and federal holidays.
- Submit applicable documentation via Kiteworks to support responses to questions and DRs. Refer to the PERM RC Fast Facts flyer *RC Secure File Transfer via Kiteworks* for information on using and requesting access to Kiteworks. See section [Sending Documentation to the RC via SFTP](#) for more information.
- Communicate findings to state Medicaid and CHIP leadership.

D. Sending Documentation to the RC via SFTP

When sending documentation to the RC, states should use the RC's SFTP site, Kiteworks. Email should never be used to transmit documents that potentially contain PII and/or PHI. Any time the state provides documentation to the RC to support a DP review, the documentation should be sent through the SFTP. Occasionally, the RC will use the SFTP to send case or system information to the state to facilitate policy and process questions. The RC may also send system access forms to the state via SFTP if the forms contain PII or may send large files that cannot be sent via email.

The state may choose to have multiple users establish access to the RC's SFTP. Users can establish accounts at any point during the cycle, but it is recommended states establish accounts before the review phase begins for the state's current cycle to troubleshoot any access issues. Sharing SFTP accounts is strictly prohibited and will result in deactivation of the account.

The RC will send instructions to states at the beginning of the cycle to help states register, send, and retrieve secure packages; change your SFTP password; and find support if needed. The instructions contain directions and screenshots to address all steps in the process. If at any time a state representative needs support or has questions regarding the RC SFTP, they should reach out to a member of the RC PERM team via email. The State User Educational Resources page within SMERF contains a detailed guide for the RC's SFTP.

E. DP Error Codes⁸

DP1–Duplicate Claim Error: The sampled line item/claim or capitation payment is an exact duplicate of another line item/claim or capitation payment that was previously paid (30 days prior or

⁸ Error codes are used to group findings at a high level and are subject to change from cycle to cycle.

60 days after the claim payment date). Services on a sampled claim conflict with services on another claim during the same DOS.

DP2–Non-Covered Service/Beneficiary Eligibility/MMIS System Error: The state’s policy indicates that the service billed on the sampled claim is not payable by the Medicaid or CHIP programs and/or the beneficiary eligibility status is not consistent between the eligibility source system and MMIS for the coverage category for the service.

DP3–FFS Payment for a Managed Care Service Error: The beneficiary is enrolled in a MCO that includes the service on the sampled claim under capitated benefits, but the state inappropriately paid for the sampled service.

DP4–TPL Error: Medicaid/CHIP paid the service on the sampled claim as the primary payer, but a third-party carrier should have paid for the service.

DP5–Pricing Error: The payment for the service does not correspond with the pricing schedule on file and in effect for the DOS on the claim.

DP6–System Logic Edit Error: This error code is no longer in use and has been retired.

DP7–Data Entry Error: This error code is no longer in use and has been retired.

DP8–Managed Care Rate Cell Error: The beneficiary was enrolled in managed care on the sampled DOS and assigned to an incorrect rate cell, resulting in payment made according to the wrong rate cell rate.

DP9–MC Payment Error: The beneficiary was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.

DP10–Provider Enrollment/Information/Screening Error: The provider was not enrolled and/or screened in Medicaid/CHIP according to federal regulations and state policy; or required provider information was missing from the sampled claim.

DP11–Claim Filed Untimely Error: The sampled claim was not filed in accordance with the timely filing requirements defined by state policy.

DP12–Administrative/Other Error: The sampled claim was missing documentation needed to complete the review.

DTD–DP Technical Deficiency: This error code is no longer in use and has been retired.

IX. Eligibility Reviews

The purpose of the eligibility case review is to identify whether a beneficiary’s eligibility determination—a new application or renewal—was processed accurately and appropriately based on applicable federal regulations and/or state policies. The most recent action on a case that made the individual eligible on the sampled claim’s DOS is under review. Eligibility determinations

are reviewed in accordance with:

- Federal regulations.
- CMS-approved state plans.
- State regulations.
- State policy and procedure manuals.
- MAGI-based eligibility verification plan and amendments.
- CMS-approved waivers.
- Federal guidance (regulatory and sub-regulatory).
- Memoranda.
- Application forms and other standardized forms.

*Disclaimer: PERM reviews against official federal regulations and state policies but will take into consideration all other items in the above list as long as they directly tie back to and are not in conflict with a federal regulation and/or state policy.

The ERC works with the state POC to obtain access to the above information.

A. Basic Eligibility Review Components

The ERC conducts eligibility reviews on cases in the eligibility sample except ELE cases, since these are excluded from review by CHIPRA. Additionally, claims that were denied by the state because no beneficiary information was available on the claim are also dropped from the eligibility sample. The ERC reviews the elements to determine whether the beneficiary was eligible for the program, service, federal match rate, and any other applicable impacts to payment. Below is a list of the most common types of elements, but it is not all-inclusive and not applicable to every beneficiary

- Household composition.
- Relationship to applicant.
- Age.
- Gender.
- Citizenship.
- Immigration status.
- SSN.
- Identity.
- Residency.
- Income.
- Pregnancy status.
- Disability and blindness.
- Elements specific to non-MAGI:
 - Resources/assets.
 - Long-term care/look-back period.
 - Medical expenses.

B. Process for Conducting Eligibility Reviews

Case Review Methodology

The eligibility case review includes a review of all relevant caseworker and system actions applicable to the determination and/or change in circumstance under review. Cases may be determined eligible solely through system or caseworker actions or cases may be a combination of system and caseworker actions.

- While reviewing caseworker actions, the ERC determines whether the caseworker made the correct determination based on information available at the time of the decision.
- While reviewing system actions, the ERC determines whether case decisions were made appropriately by the system and whether the appropriate information was verified through the applicable data sources.

Verification of All Relevant Eligibility Elements

The ERC reviews to determine that all appropriate eligibility elements on the case were appropriately verified by the state.

Verification can be hard-copy documents or third-party data matches that confirm information about the beneficiary's circumstances and must meet appropriate federal and state regulation and policy to be acceptable. All eligibility elements are required to be verified, except those allowed to be self-attested, as indicated by federal laws and regulations and the state's policies.

Verifications, where necessary, must be current as of the time of the action under review and must be made available to the ERC for review. When federal and state regulations/policy allow, verifications may be done after eligibility determinations for some initial applications. In cases of allowable post-eligibility verification, the ERC will review to determine if the appropriate verification was completed in the required timeframe.

In cases where federal regulation and state policy allow self-attestation, elements of eligibility are considered to be verified with a statement under penalty of perjury from the household.

Determination of Beneficiary Eligibility

The ERC reviews to determine that the beneficiary determination was correct and if the beneficiary was:

- Determined eligible timely.
- Eligible for the program.
- Eligible for the service provided.
- Assigned an eligibility category by the state that resulted in an FMAP different from the FMAP associated with the correct eligibility category.
- Determined using other considerations relevant to the beneficiary's eligibility, such as whether the contribution to care was correct for long-term care.

IV of Eligibility Reviews

IV is a process performed by the ERC to determine if a beneficiary would have been eligible

when evidence in the case file for applicable eligibility elements is missing but other case file or electronic data match information is available to apply to the eligibility review. IV is conducted for cases with ER1, ER2, and ER3 error codes where there is missing documentation for eligibility elements and verification could be obtained without contacting the beneficiary. Reviews that contain error codes unrelated to missing documentation are not assessed for IV.

During the ERC's eligibility case review, if any elements were not verified during the determination or evidence for verified elements is missing, the ERC will attempt to independently verify the element using information in the case file. The ERC will only use information that would have been available to the state at the time of the determination, including electronic data matches that are available in the eligibility system, or documentation provided by the household for another benefit program. If the ERC does not have access to the necessary verification or is not able to use existing eligibility system access to independently verify a missing element, the ERC will request the information from the state by adding information to the EP1 list. The request will include the initial documentation used to complete the determination under review and may also include other types of evidence that were not used for the determination but were available in the case file and could support beneficiary eligibility as of the last action date. States are encouraged to prioritize submitting the initial documentation from an eligibility determination, if requested. If the initial documentation from the eligibility determination is found, these errors could be overturned. States are encouraged to check the EP1 in SMERF list frequently and respond timely to requests for additional documentation or information.

Although the ERC will collect and accept IV, an ER1, ER2, or ER3 error will still be cited and reported in SMERF. While any IV findings will not change the actual finding of the PERM review, the ERC and CMS will categorize these findings as technically improper for OMB reporting purposes when the ERC can independently verify that the beneficiary was eligible for the determination under review. Technically Improper Payment is defined within [Appendix C of the OMB A-123 Circular](#) as "a payment made to an otherwise qualified recipient for the right amount, but the payment failed to meet all regulatory and/or statutory requirements." A technically improper payment is a non-monetary loss type of improper payment.

Eligibility reviews completed with the assistance of IV will be considered technically improper payments. An example is when a state fails to perform or document an income verification when determining beneficiary eligibility and where the ERC is able to independently verify that the beneficiary would have been eligible using the same data available to the state at the time of determination. Since the state did not complete and/or document the verification, an improper payment will remain on all state-specific findings documents, but the ERC will categorize the IV finding as technically improper for OMB reporting.

IV results will be provided to CMS and states at the end of the cycle. IV attempts to gain more information about insufficient documentation payment errors. If more information is known about this group of improper payments, CMS can further evaluate the definition of an improper payment. Although the official improper payment rate will include insufficient documentation payment errors, the ERC will document eligibility elements that can be independently verified during the cycle, separately record eligibility review findings (if applicable) that result from IV,

and provide that information to CMS and states.

Case Review Considerations

The sections above outline the process for reviewing types of cases most likely to be observed in the universe. However, there will likely be other types of cases reviewed, for which the process differs slightly. These other situations are described in more detail below.

Process for Reviewing Renewals

Regulations at [42 CFR § 435.916\(a\)](#) requires eligibility to be determined at least once every 12 months. The ERC will review the case record and eligibility system to determine the date of the most recent application or renewal prior to the DOS of the claim to determine the timeliness of the renewal.

In some instances, beneficiaries may submit information at the end of, but still within, the 12-month timeframe. In these cases, the ERC will review to determine if the state met either the 12-month timeframe for redetermination or the state's policy for timely review and completion of redeterminations with information submitted at the end of the timeframe. If either timeframe was met, there will be no finding cited related to redetermination timeliness.

In instances where no redetermination has been conducted within 12 months prior to the DOS on the sampled case, the ERC will determine if there was a redetermination conducted between the DOS and the sampled date of payment. If a complete and accurate determination was conducted prior to the sampled date of payment, the ERC will cite an observation. If no redetermination was conducted, the ERC will cite an improper payment.

Process for Reviewing Income Verifications Against FTI

For income verification, states have the option to use the FDSH or other data sources for income verification. However, Internal Revenue Service (IRS) statute 6103 of the Internal Revenue Code prohibits states from disclosing FTI to any outside source, including CMS improper payment measurement programs. In order to avoid any burden on states to provide statutorily prohibited information, PERM will not review for an indicator to confirm state income verification against the Hub where FTI was the sole verification source but instead require an attestation that the verification was done appropriately.

Waivers

Waivers give states authority to deviate from their approved Medicaid or CHIP state plans. These waivers can focus on a number of different elements including populations served, eligibility criteria, enrollment periods, enrollment caps, and services provided. Waivers are generally tailored to a state's specific needs and, therefore, must be reviewed against state-specific rules for the approved waiver program. Waiver programs may incorporate the following elements that must be considered in case reviews, including:

- Special populations.

- Premium payments.
- Enrollment or re-enrollment requirements.
- Other special eligibility requirements.

SSI

[Section 1634](#) (42 U.S.C. 1383c) of the Act allows states to enter into an agreement with the Commissioner of Social Security to provide Medicaid coverage to beneficiaries of SSI. In a “1634 state,” individuals deemed eligible for SSI by the SSA are automatically enrolled in Medicaid. Individuals who receive SSI will be included in the eligibility case review, as many of them will have associated claims in the FFS and MC universes. For these cases, the ERC will review to verify dates of SSI eligibility.

[Section 209\(b\)](#) (P.L. 92-603) of the Act, as amended, allows states to place more restrictive income requirements on individuals collecting SSI and applying for Medicaid. For these cases, the ERC will review to verify dates of SSI eligibility and state-specific requirements for Medicaid eligibility under the 209(b) rule.

Title IV-E Adoption Assistance and Foster Care

Medicaid eligibility is authorized under Title IV-E Adoption and Foster Care assistance for children who have a Title IV-E adoption assistance agreement or who receive Title IV-E foster care or guardianship maintenance payments. Similar to the SSI program, Medicaid is authorized without a separate determination of eligibility. As such, verification of current Title IV-E status is verification of eligibility for Medicaid.

Contribution to Care

Contribution to care/patient pay is the amount that a beneficiary must pay toward long-term care costs. The state will decrease the amount paid to the long-term care institution by that same amount. The contribution to care/patient pay amount is established in a separate calculation that occurs after the eligibility determination. This is why it is sometime referred to as post eligibility treatment of income. Income that may be disregarded in the eligibility calculation may be included in the Contribution to Care calculation. The federal regulations are also specific on the allowable deductions and the order in which they must be applied.

The ERC will review the contribution to care/patient pay amount for long term care cases in which a contribution to care apply. If the calculation is determined to be incorrect and the service was related to long-term care, the ERC will cite a partial payment error when the difference is less than the total amount of the sampled claim. The payment error is the difference between the contribution to care/patient pay amount that was used by the state and the correct amount that should have been used. If the service was not related to long-term care, the ERC will not cite an error because there was no impact to the payment that was sampled. The ERC will document an observation to share the finding. For example, if the claim is for a specialist who sees the beneficiary at the long term care facility and bills separately, the claim would not be impacted

by the contribution to care and would have been paid correctly because the beneficiary is otherwise eligible for Medicaid.

Eligibility Categories with Different Benefit Packages

Some eligibility categories may cover different services, such as Emergency Services Only categories for enrollees who are unqualified non-citizens. Eligibility categories with different benefit packages may lead to eligibility errors in two ways: 1) when a beneficiary was incorrectly enrolled in a benefit package that covers more services than the correct eligibility category and 2) when a beneficiary who was enrolled in the correct eligibility category receives a service for which he or she was not eligible. Unless the claim is adjusted, a beneficiary receiving a service for which he or she was not eligible would result in an error. If the ERC determines that a beneficiary is in an incorrect category with different benefits, the ERC will attempt to determine if the service sampled on the claim is covered by the eligibility category. An error will be cited if the service provided is not covered. Otherwise, no finding will be cited for eligibility discrepancies that do not result in an inappropriate service provided.

SSA Data

For reviews requiring SSA data, states are obligated to provide that information to the ERC. PERM has been granted permission from the SSA in order to view and access SSA data as it pertains to eligibility reviews.

Review of FFE Cases

All Medicaid and CHIP cases paid under Title XIX and Title XXI may be included in the eligibility case review based on the random selection of FFS and MC claims. Upon sampling, the ERC, with the state's assistance, will conduct a crosswalk of the sampled claim to identify the case within the eligibility system for all cases sampled, including FFE-D and FFE-A cases. This information will be utilized to identify case background information, including the channel of application. Once the ERC establishes whether the case came to the state via an inbound AT file from the FFE, the ERC will determine if the AT file will be requested from the state. The ERC will review the AT file and caseworker and system actions.

Preparation and State Responsibilities

The ERC and the state perform the following preparation activities prior to the start of eligibility reviews:

- Provide copies of state policies. After the ERC identifies and obtains publicly available state eligibility policies, the state will need to provide any additional relevant non-public policies. Begin assembling policy documentation, including policy materials and caseworker manuals.
- Execute DUAs, Non-Disclosure Agreements and other security agreements. The state will need to provide the ERC with access to its eligibility systems. Determine the state's process for providing remote system access to the ERC, including DUAs, background checks, and system access forms.

- Complete Eligibility Intake Protocol. A prepopulated Intake Protocol will be sent to the state for review. Identify the staff members with subject matter expertise to review the Intake Protocol, make updates to documented policies and processes for the state's eligibility determinations.
- Complete the Eligibility System Access Questionnaire. A prepopulated System Access Questionnaire will be sent to the state for review. The Questionnaire contains questions that provide information regarding the state's eligibility system(s), system access requirements, system functionality and data matching capabilities. The state may assign a point of contact to assist with troubleshooting system access challenges during the cycle.
- Complete the Eligibility Category Mapping. A prepopulated Eligibility Category Mapping will be sent to the state for review. The state will confirm that the state's eligibility categories are properly mapped to federal eligibility categories and federal matching rates.

State Responsibility Prior to Starting Eligibility Reviews

- Attend the Eligibility Intake Meeting. The state will participate in an Intake Meeting to assist the ERC's preparation for the eligibility review process. During the meeting, the ERC may ask clarifying questions from the state's responses to the Intake Protocol, the System Access Questionnaire and the Eligibility Category Mapping documents. The ERC will also share an overall timeline for the eligibility review process once system access is gained.
- Review the Eligibility Case Review Planning Document. The state will receive a prepopulated Case Review Planning Document that summarizes policy and process information that is used for the eligibility reviews and should be reviewed by the state for accuracy.
- Provide system access. In addition to providing remote access to eligibility systems, states must provide any required system and security trainings as needed.

State Responsibility Throughout the Cycle Period

- Assist in the collection of case records. The state should collect relevant case materials that the ERC may not have access to, including documentation missing from case files that are on the EP1 list in SMERF. Case records that contain hard copy documents should be transmitted electronically to the ERC.
- Respond to additional documentation requests (ADR). The state will review the pending report (EP1) in SMERF and send additional documentation needed for eligibility reviews. States have 30 calendar days to submit additional documentation. Submit applicable documentation via ERC's MoveIt SFTP site. [Refer to the Fast Facts for the ERC's SFTP]
- Review eligibility review findings and reports. The state will review findings and reports in SMERF. Follow the difference resolution and appeal process for each case finding as needed. Track errors and request DR within 25 business days after findings posted to SUD and/or request appeals within 15 business days after the DR decision date for disputes of finding. Business days exclude weekends and federal holidays. State can also submit missing documentation for ER1, ER2 and ER3 errors. As part of

its review a state should ensure that the correct federal match percentage is applied to the sampled claim.

- Attend bi-weekly check-in meetings. The ERC and state will participate in biweekly meetings through the PERM cycle to discuss the progress of eligibility reviews, review findings and any policy or process issues that arise. The state should determine the appropriate staff members who will attend the meetings and ensure that relevant staff members are available based on specific agenda topics.

C. Sending Documentation to the ERC via SFTP

When sending documentation to the ERC, states should use the ERC's SFTP site. Email should never be used to transmit documents that potentially contain PII/PHI. Any time the state responds to an ERC documentation request, the documentation should be sent through the SFTP. Occasionally the ERC will use the SFTP to send case or system information to the state to facilitate policy and process questions. The ERC may also send system access forms to the state via SFTP if the forms contain PII or may send large files that cannot be sent via email.

The state may choose to have multiple users establish access to the ERC's SFTP. Users can establish accounts at any point during the cycle, but it is recommended states establish accounts before the review phase begins for the state's current cycle to troubleshoot any access issues. Sharing SFTP accounts is strictly prohibited and will result in deactivation of the account.

The ERC will send instructions to states at the beginning of the cycle to help states register, send, and retrieve secure packages; change your SFTP password; and find support if needed. The instructions contain directions and screenshots to address all steps in the process. If at any time a state representative needs support or has questions regarding the ERC SFTP, they should reach out to a member of the PERM team through the PERM ERC inbox at PERM_ERC@bah.com.

D. ER Error Codes⁹

ER1–Verification was not maintained as audit evidence; Unable to confirm beneficiary eligibility: The state cannot provide documentation obtained during the state's eligibility determination. Evidence within the eligibility case file or eligibility system indicated that the state verified the eligibility element using an appropriate verification source during the state's eligibility determination, but the documentation of the verification source was not maintained. The beneficiary under review may be financially and categorically eligible but eligibility cannot be confirmed without the documentation.

ER2–Verification was not performed as required at the time of eligibility determination; Unable to determine beneficiary eligibility: The state cannot provide documentation obtained during the state's eligibility determination. In addition, the state cannot provide evidence the state obtained documentation from an appropriate verification source during the state's eligibility

⁹ Error codes are used to group findings at a high level and are subject to change from cycle to cycle.

determination. The beneficiary under review may be financially and categorically eligible, but eligibility cannot be confirmed without the documentation.

ER3–Determination not conducted as required; unable to determine beneficiary eligibility: The state could not provide evidence the state conducted an eligibility determination, or the state completed an eligibility determination that was not in accordance with timeliness standards defined in federal regulation.

ER4–Not eligible for enrolled program; financial issue: The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action affecting the financial elements of the eligibility determination.

ER5–Not eligible for enrolled program; non-financial issue: The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action affecting the non-financial elements of the eligibility determination.

ER6–Should have been enrolled in a different program (i.e., Medicaid or CHIP): The beneficiary is not eligible for the enrolled program (i.e., Medicaid or CHIP), but is eligible for the other program.

ER7–Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment: The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category within the program, which results in an incorrect FMAP assignment for the beneficiary.

ER8–Not eligible for enrolled eligibility category; ineligible for service provided: The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category with the same FMAP, which results in the individual receiving services for which he or she is not eligible.

ER9–FFE-D error: Not applicable to states; used for errors when the FFE incorrectly determines eligibility for the beneficiary.

ER10–Other errors: The beneficiary is improperly denied or terminated or the contribution to care calculation is incorrectly calculated.

ERTD1–This error code is no longer in use and has been retired.

ERTD2–This error code is no longer in use and has been retired.

X. DR and CMS Appeals Processes

Through SMERF, states may dispute error and deficiency findings by filing DR requests with the RC and the ERC and by appealing DR decisions to CMS. These appellate procedures ensure that PERM provides states with due process protections by allowing them to seek redress for findings they dispute.

A. DR Process

The DR process is the first formal means by which states can dispute errors and deficiencies cited by the ERC and RC, including all eligibility error findings, DP error findings, and MR error findings. The RC officially reports eligibility, DP, and MR errors to the state through SUD reports that are published on the 15th and 30th days of each month. The publication of a SUD report starts the state's timeframe to dispute errors identified in the SUD report. From the date the SUD report is posted, states have 25 business days to file the DR (the SUD report date is day 1). Business days exclude weekends and federal holidays. States submit the DR request via SMERF. Instructions for requesting a DR through SMERF are located in the SMERF State User Guide on the [SMERF homepage](#). States can look at errors on their tool bar in SMERF by selecting MR, DP, or Eligibility; once the category is selected, states can see their DRs and Appeals. States may refer to the SMERF User Guide for additional information on these steps.

If a review has multiple error findings, the state must request DRs and appeals separately for each finding it wishes to dispute. This allows each finding to move through the process independently. For example, an MR may have two findings, an MR6 and an MR8 error. The functionality allows the state to file a DR on the MR6 error on the 10th day after the SUD report and then file a separate DR for the MR8 on the 20th day after the SUD report. The state could also file DRs for both errors on the same day. MR is used in the example, but this is also true for DP and eligibility reviews.

All DR requests are submitted through SMERF and, if additional documentation is required, it should be sent to the appropriate review contractor via the contractor's SFTP. DR requests for MR and DP reviews will be reviewed by the RC and DR requests for eligibility review will be reviewed by the ERC. SMERF will prompt the state after filing the DR with the appropriate contact information for providing additional documentation on the DR.

The contractor reviews the DR request and issues a decision upholding, modifying, or overturning the initial PERM error finding. Once the appropriate contractor has determined whether to reverse, modify, or uphold the original review decision, the decision is posted in SMERF and notifies the state via email so the state will know to access SMERF to view the results of the DR. If the state is satisfied with the DR decision, it does not need to take any further action. To dispute the DR decision, the state should access SMERF and file an appeal to CMS.

States should follow the procedure described in [42 CFR § 431.998](#) when submitting any DR to the contractors or CMS.

42 CFR § 431.998 DR and appeal process.

To file a DR/appeal request, the state must:

- (1) Have a factual basis for filing the request.
- (2) Provide the appropriate federal contractor/CMS with valid evidence directly related to the finding(s) to support the state's position.

A factual basis for filing a DR or appeal should include a brief explanation about the reason for

the disagreement, relevant policy references, and/or specific references to submitted documentation and how that documentation addresses the finding. Evidence to support the DR or appeal must be submitted on or before the date that the DR or appeal is requested. Evidence submitted after requesting a DR or appeal may not be reviewed prior to the determination.

Although states can file DRs and appeals for deficiencies, deficiencies have no impact on a state's improper payment rate and there is no federal dollar amount associated with the finding for recoveries or disallowance purposes.

The official PERM reports and improper payment rates include the results of all DRs and appeals completed prior to finalizing data (including any DRs or appeals filed after cycle cutoff but still within allowable timeframes).

Eligibility for DR

The following terms and conditions apply to the DR process.

- States must request DR within 25 business days after the RC publishes the SUD report.
- All eligibility, MR (except for MR1), and DP errors are eligible for DR, including multiple errors per claim; MR1 errors are not eligible for DR because no documentation was submitted by providers to review.
- States do not need to file a DR for MR1 errors to submit requested documentation, MR2 errors where the provider or state is submitting the requested documentation, and for the state to submit the information necessary to reprice the claim for partial MR errors; the state is encouraged to utilize the DR process to request repricing of MR partial errors if it is still within 25 business days of the SUD; and states are also encouraged to work with providers to submit missing documentation (MR1/MR2 errors).
- A DR request must contain, at a minimum:
 - The factual basis for the state's dispute.
 - Valid evidence that demonstrates the error finding was erroneous.

Repricing MR Partial Errors during DR

Some MR error findings are able to be repriced. This means states have an opportunity to furnish new information to the RC that supports repricing to a partial payment error rather than a 100% payment error. The RC is not able to determine the appropriate partial payment amount that would have been allowed and processed through the claims system since the RC cannot duplicate all of the edits that may have applied to that claim. The state must create and provide documentation from the state claims payment system to support what the claim pricing would have been in the claims system if the claim had been filed correctly by the provider and the claim paid at that time.

Repricing could occur on any MR errors; however, in most circumstances, repricing applies to:

- MR3 (Procedure Coding Error).
- MR4 (Diagnosis Coding/DRG Error).
- MR5 (Unbundling Error).
- MR6 (Number of Unit(s) Error).
- MR7 (Medically Unnecessary Service Error).

- MR10 (Administrative/Other Error).

For partial MR errors, the state can review the assigned error amounts to determine if it should seek repricing. States may submit documentation to reprice until the cycle cutoff date, but CMS recommends that the state reprice partial errors as soon as possible in order to work through any documentation issues before the cycle cutoff. If states are within 25 business days of the SUD, states may utilize the DR process to reprice the error.

If states have documentation related to repricing and wish to submit this outside of the DR/appeals timeframe, states must:

- Submit the documentation to the RC via:
 - SFTP—The RC’s secure file transfer solution: send an email to the PERM RC to request an SFTP account, if needed.
 - Fax—Please include a cover sheet with PERM ID noting that the documentation is for repricing.
- Provide written documentation to the RC verifying the accuracy of the repricing for the RC to consider a sampling unit for repricing; if the state does not provide sufficient documentation and rationale during the request for repricing, the RC is unable to process the state’s request
- Send an email to the RC and your CMS PERM State Liaison with the:
 - PERM IDs for the submitted documentation.
 - Number of pages for each PERM ID.

The RC will review the documentation within 10 business days and let the state know if the documentation was sufficient to reprice the claim or not and why.

When the state supplies acceptable repriced documentation, the RC calculates the amount in error by taking the amount the state paid minus the amount that the state should have paid. If the result is a positive number (indicating the state should have paid less than it did), then the amount in error is an overpayment. If the result is a negative number (indicating the state should have paid more than it did), then the amount in error is an underpayment. If the state does not provide acceptable repriced documentation, then the error will be 100 percent of the paid amount for that sampling unit.

B. State Appeal to CMS

An appeal to CMS is the last step of the process that states can use to dispute the ERC’s eligibility findings or the RC’s MR or DP findings. A state may only appeal error findings upheld by the contractor’s DR decision. If the state disagrees with the contractor’s DR decision, it may file an appeal with CMS asking that the DR decision be overturned or modified. However, states cannot appeal findings to CMS without first seeking redress through the DR process.

The deadline for filing an appeal is 15 business days after notification of the DR decision via PERM alert email. Business days exclude weekends and federal holidays. States must submit all documents to the RC or ERC when requesting appeal. If a state/provider submits new documents to CMS for appeals, the claim will roll back to the relevant contractor for further review.

States should follow the procedure disclosed in [42 CFR § 431.998](#) when submitting any appeal to CMS.

Notification of CMS Appeal Rights

The RC or ERC posts the DR decision to SMERF and notifies states via email that the DR decision is available for review. This notification will describe the state's appeal rights.

CMS Appeal Eligibility

Per 42 CFR § 431.998, for the CMS appeals process:

- The state must first dispute the PERM error finding through the DR process.
- The state must file its appeal to CMS through SMERF within 15 business days from the date the contractor posted its DR decision.
- The state must submit all documentation or evidence relevant to the appeal at the time the appeal is requested.
- The state must have a factual basis for appeal.

CMS Appeal Process

The state, the RC/ERC, and CMS receive an email confirmation once the state files an appeal. Upon receiving the state's appeal, the RC or ERC provides CMS with access to the entire sampling unit record. The sampling unit record is a case file comprised of:

- A copy of the original PERM claim.
- All medical records, case documentation, or other documentation received by the contractor.
- State policies pertaining to the claim.
- Screenshots collected during review.
- The contractor's review notes.
- The state's written arguments and supporting evidence it presented during the DR proceedings.
- The state's written arguments and supporting evidence it presented during the appeal to CMS.

CMS convenes a panel of PERM clinical and policy experts to review appeals. CMS may also reach out to the state during this time. Once CMS issues a decision, the state will receive an email notice that the appeal decision is available for review in SMERF. The CMS review panel's decision is final and binding on states, as it is not reversible and marks the final step in the dispute process.

Receipt of Additional Documentation during the Appeals Process

If the state pursuing an appeal submits documentation to CMS that was not submitted to the RC or ERC during the contractor's initial review or subsequent DR, the new documentation is first reviewed by the contractor and the finding is addressed appropriately based on the documentation received. This does not limit a state's right to have the appeal reviewed by CMS.

XI. Errors and Improper Payment Rate Calculation

In determining a PERM improper payment rate at the individual state level, at the national level,

and for any program, the methodology is identical: the PERM improper payment rate is the ratio of estimated improper payments to estimated total payments.

Improper payments are determined by the appropriate MR, DP review, and eligibility review and are considered the absolute dollar value of the improper payment. An improper payment is generally the difference between what *was* paid and what *should have been* paid. The RC and ERC will reconcile all claims when more than one error is identified under MR, DP review, or eligibility review before reporting the final findings to the SC for the national improper payment rate calculation. Final PERM overpayment error amounts cannot exceed the total paid amount on the claim.

The total improper payments and total payments are estimated by extrapolating the sample errors and sample payments to the universe based on the appropriate sampling frequencies. It is important to note that the PERM improper payment rate is not a “fraud rate” but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements.

A. Cycle Cutoff

The cycle cutoff date is set for the April 15th prior to official national and state-specific reporting of each cycle. However, CMS may push back the cycle cutoff date depending on the progress of the cycle. States and providers are required to submit all outstanding documentation by the cycle cutoff date unless the allowable timeframe extends past the cutoff date.

B. Adjustments

PERM uses the original payment date and original payment amount to determine what was paid, with the exception of any adjustments made within 60 days of the original paid date.

PERM does not consider adjustments made outside of the 60-day timeframe allowed under PERM in determining whether to cite a payment error. The reviewer determines if the payer made a correct payment based on the policies in effect at the time of the payment and the state’s compliance with its payment policies. That is, the reviewer compares the payment amount to the amount the payer should have paid, at the time payment was made. For example, if prices are changed retroactively but the changes are made outside of the 60-day adjustment timeframe, it is not an error *if the payment made was based on the pricing schedule on file at the time payment was made*.

C. Improper Payment Rate Calculation

PERM will calculate the improper payment rates for each program. PERM calculates a total of four improper payment rates for Medicaid and CHIP.

- An FFS payment improper payment rate.
- An MC payment improper payment rate.
- An eligibility improper payment rate.

- A combined improper payment rate.

D. State-Level Improper Payment Rate Calculation

States participating in PERM have up to six separate components.

- Medicaid FFS.
- Medicaid MC.
- Medicaid Eligibility.
- CHIP FFS.
- CHIP MC.
- CHIP Eligibility.

Each component has a set number of claims that will be reviewed for the component improper payment rate. Because the payment components (i.e., FFS and MC) use independent universes, the improper payment rates are additive. Since the eligibility component does not have an independent universe, a correction factor is applied to estimate the total program improper payment rate, under the assumption that eligibility errors are independent of the other types of errors.

The state-level improper payment rate is estimated as:

$$\hat{R}_i = \frac{\hat{t}_{e_i}}{\hat{t}_{p_i}}$$

In the equation, \hat{R}_i is the estimated improper payment rate for state i ; \hat{t}_{e_i} is the estimated dollars in error projected for state i and \hat{t}_{p_i} is the estimated total payments for state i . Then,

$$\hat{t}_{e_i} = \sum_{j=1}^a \frac{M_{i,j}}{m_{i,j}} E_{i,j}$$

and

$$\hat{t}_{p_i} = \sum_{j=1}^a \frac{M_{i,j}}{m_{i,j}} P_{i,j}$$

In these equations, $M_{i,j}$ is the total expenditures in the universe for state i in stratum j and $m_{i,j}$ is the total expenditures in the sample for state i in stratum j . The ratio of payments in the universe to payments in the sample is the inverse of the sampling frequency with respect to expenditures. Dollars in error in the sample for stratum j and state i , denoted $E_{i,j}$, is weighted by the inverse of the sampling frequency to estimate dollars in error in the universe for that stratum. In this example, the total number of strata is denoted by a .

For example, if all claims in the universe in stratum j are worth \$10,000, and the total number of claims sampled from stratum j adds to \$100, the weight for the dollars in error in the stratum j sample is 100 (or \$10,000/\$100). The estimated total dollars in error are then added across each of the a strata to obtain total dollars in error for the universe. Total payments are estimated in the same

way, where $P_{i,j}$ is the total payments in the sample in stratum j for state i .

Combining Claims Review Improper Payment Rates across Program Areas

Combining the claims review improper payment rates (i.e., combining the FFS and MC improper payment rate for Medicaid and the FFS and MC improper payment rate for CHIP) is relatively straightforward given that population payments are known. Note that CMS does not use true population payments in calculating state rates for each program area. The reason for this is two-fold. First, the combined ratio estimator allows for correction of possible bias if the sampled average payment amount differs from the universe average payment amount. If CMS used a combined ratio estimator to combine the program areas at the state level, one program area that realized high sample average payment amount compared to the universe average would have too much influence in projections. Second, combining program area rates using the shares of expenditures as weights reduces the variance in the estimates from this source. Furthermore, following this method allows the same method for combining program area claims review rates at both the state and national level.

The following equations use the estimated state or national improper payment rates and variances calculated in the previous two sections.

Let the overall claims review improper payment rate for Medicaid or CHIP be defined as:

$$\hat{R}_C = \frac{t_{p_{FFS}} \hat{R}_{FFS} + t_{p_{MC}} \hat{R}_{MC}}{t_p}$$

where

$$t_p = t_{p_{FFS}} + t_{p_{MC}}$$

In this equation \hat{R}_C is the combined improper payment rate for FFS, MC, or combined (C) and represents total payments for FFS, MC, or the total, depending upon the subscript of the variable. It equals the numerator of total payments for FFS ($t_{p_{FFS}}$) times the error rate for FFS (\hat{R}_{FFS}), plus the total paid for MC ($t_{p_{MC}}$) times the error rate for MC (\hat{R}_{MC}). This sum is then divided by total payments (t_p). Total payments is the sum of total FFS ($t_{p_{FFS}}$) plus managed care ($t_{p_{MC}}$).

Combining Claims Improper Payment Rates and the Eligibility Improper Payment Rate

The claims rate and the eligibility rate are not mutually exclusive. Combining the two achieves a total, or combined, improper payment rate, which necessitates netting out the estimated overlap in projected error.

After combining the FFS and MC components of each program into one overall claims improper payment rate for Medicaid and one for CHIP, respectively, at the state and national levels, these rates are combined with the respective eligibility improper payment rates for each program. The combination of the claims review rate and the eligibility rate will be referred to as the combined improper payment rate. The estimated combined improper payment rate is given by:

$$\hat{R}_T = \hat{R}_C + \hat{R}_E - \hat{R}_E \hat{R}_C$$

where \hat{R}_T denotes the estimated Total, or Combined Improper Payment Rate, \hat{R}_C denotes the estimated Claims Improper Payment Rate, and \hat{R}_E denotes the estimated Eligibility Improper Payment Rate.

Continued Processing

Continued processing occurs when a claim did not have time to go through the full PERM process before finalizing the official national and state-specific reporting. An example includes rare occurrences when changes to findings are made after the data was finalized for official reporting.

Claims will complete the PERM process through continued processing and CMS will recalculate a state's improper payment rate based on any changes as a result of the continued processing determinations.

By PERM regulation, providers must submit medical documentation within 75 calendar days of the RC's Initial Request or by the cycle cutoff date. Therefore, CMS will not accept any new documentation after the cycle cutoff date that is not within 75 calendar days of the date of the initial request letter or within 14 calendar days of the date of the additional documentation request letter. Medical documentation received after the cycle cutoff date but within the record request timeframes will be included in the national and state-specific reporting and will not be part of continued processing unless it is received after the time that data must be finalized for official reporting. However, if a state has documentation outside these timeframes to support that a claim previously called an error was correctly paid (e.g., successful provider appeal results, claim adjusted after PERM 60-day window), it can work with its CMS PERM State Liaison or CMS DFO representative to file a recoveries exception request.

States may contact the CMS DFO financial contact to determine what adjustment to the expenditure reports is required for recovery purposes. Please see [Recoveries](#) and [Exceptions](#) for more information on this process.

E. National Rolling Improper Payment Rate Calculation

To go from the improper payment rates for individual states to a national rolling improper payment rate, the most current data available from all 52 states (including Puerto Rico starting in RY27) is first aggregated. This data includes the 17 or 18 states in the most current sample, as well as samples from the previous two years. Each state is benchmarked to its reported payments from the year it was sampled. Using the state expenditures as weights guarantees that a state's impact on the national rolling improper payment rate is proportional to the size of its payment.

Then, the error and payment amounts by component are combined across all 51 or 52 states to calculate the national rolling component improper payment rates for FFS, MC, and eligibility. The component improper payment rates are combined to form the overall national rolling improper payment rate, following the same method as used in calculating the overall state improper payment rates.

The formula for calculating each component improper payment rate is:

$$\hat{R} = \frac{\sum_{i=1}^{51} t_{p_i} \hat{R}_i}{t_p}$$

where \hat{R} is the national rolling improper payment rate, t_{p_i} is the total expenditure for state i , and \hat{R}_i is the estimated improper payment rate for state i . The sum of the error amounts across all 51 states is then divided by t_p which is the total national expenditure. Note that for future national calculations including 52 states, the above equation would be applied to all 52 states.

Note that there is no “^” over the state and national payment data. This means that they are not estimated from the sample. These are actual payment expenditures. Hence, the national rolling improper payment rate has an intuitive interpretation as a weighted sum of the estimated state improper payment rates, where the weights are shares of expenditures.

F. Cycle Improper Payment Rate Calculation

The cycle improper payment rate is calculated using a similar method to the one used in calculating the national rolling improper payment rate. The component improper payment rates are calculated using the weighted sums of improper payments and total expenditures across the 17 or 18 cycle states. Then, the cycle improper payment rate is calculated using the component improper payment rates.

$$\hat{R}_H = \frac{\sum_{i=1}^{17} t_{p_i} \hat{R}_i}{t_h}$$

where \hat{R}_H is the 17-state cycle improper payment rate, t_{p_i} is the total expenditure for state i , \hat{R}_i is the estimated improper payment rate for state i , and t_h is the total expenditure from the 17 states in the cycle. Note that for cycles with 18 states, the above equation would be applied to 18 states.

G. Improper Payment Rate Reporting

At the conclusion of each PERM cycle, state-specific reports are shared for each program (Medicaid and CHIP). The following reports are submitted to states, typically in November, once national improper payment rates are published in the AFR.

Error Rate Notification letter: The letter contains the official state program improper payment rate, overall and by component (i.e., FFS, MC, eligibility), as well as preliminary sample sizes and improper payment rate targets for the state’s next PERM cycle.

CSR: The report contains analysis of the error findings for each component (i.e., FFS, MC, eligibility), including specific information on each error based on RC and ERC sampled claim reviews.

CAP: The CAP helps guide the state in identifying the root cause for each error and deficiency found in a measurement and establish the appropriate corrective actions to resolve each error and

deficiency found.

Other Report Types: In addition to official state-specific reporting documents, states may receive reports outlining more finding information on COVID-19 review impacts, IV findings, observation findings, etc.

XII. Improper Payment Rate Targets

OMB guidance for implementing PIIA requires CMS to set targets for future erroneous payment levels for Medicaid and CHIP. Provided CMS has estimated a baseline improper payment rate for the program, CMS is required to include a target for the program's future erroneous payment rates in the AFR. Targets are expected to be lower than or equal to the most recent estimated improper payment rate.

A. National Improper Payment Rate Targets

CMS sets targets for the official three-year rolling national program improper payment rate. Target improper payment rates are set one year out from the most recently published improper payment rate and are negotiated by OMB, HHS, and CMS. The HHS AFR and [paymentaccuracy.gov](https://www.hhs.gov/program/operational-requirements/policy/affirmative-finding-report) list the current improper payment rate targets.

B. State-Specific Improper Payment Rate Targets

The national Medicaid and CHIP improper payment rates are a compilation of state-specific improper payment rates and, therefore, collaboration between CMS and the states is vital in achieving the national improper payment rate target. CMS sets state-specific overall program and component improper payment rate targets that allow CMS to collaborate with states to meet the national target.

When setting state-specific improper payment rate targets, CMS asks states to reduce their component improper payment rates by a fixed proportion relative to an “anchor” rate. The anchor rates are currently set at 3 percent for FFS and 1 percent for MC. Each state must reduce the difference between the previous component improper payment rate and the component anchor rate by 50 percent. States with FFS or MC component improper payment rates in the previous measurement that are less than the anchor rates will be expected to achieve the same or better improper payment rate in the next measurement period. Eligibility target rates are currently set at 3 percent per 1903(u) requirements.

See *Exhibit 7* for an example of how PERM calculates state-specific target improper payment rates.

Exhibit 7: Example Calculation of State-specific Target Improper Payment Rates

	FFS	MC	Eligibility	Overall
Prior Rate	13.9%	0.04%	N/A	
Anchor Rate	3%	1%	N/A	
Difference between rate and anchor rate	10.9%	N/A (under anchor)	N/A	
50 percent of the difference	5.5%	N/A	N/A	
Target Rate	8.5%	0.04%	3%	6.6%*

* Note: The overall target rate is calculated by first combining the FFS and MC target rates in a weighted average based on the total FFS and MC expenditures. Then, the claims target rate is combined with the eligibility target rate to calculate the overall target rate.

State-specific targets for a given PERM cycle are available when state improper payment rates are released from the previous PERM cycle.

CMS may consider suggested adjustments to component targets, given the overall state target does not increase. There are currently no penalties or rewards in place if states do or do not meet their improper payment rate targets.

XIII. CAP Process

The PERM CAP regulation at [42 CFR § 431.992\(c\)](#) requires each state to submit to CMS and implement a corrective action plan for the FY it was reviewed no later than 90 calendar days after the date on which the RC posts its improper payment rates on SMERF.

Following each measurement cycle, states must complete and submit CAPs for Medicaid and CHIP via the Medicaid and CHIP reporting portal based on errors and deficiencies found in the FFS, MC, and eligibility components of the PERM measurement.

The PERM CAP process is administered and supported by CPI. In an on-going effort to reduce the improper payment rates in Medicaid and CHIP, a PERM CAP team has been established to provide technical support to states with CAP development, monitoring, evaluation, and training.

The PERM CAP process involves analyzing findings from the PERM measurement, identifying root causes of errors and deficiencies, and developing corrective actions designed to eliminate or reduce major causes of errors trends or other vulnerabilities. Each state's current year CAP must also include an evaluation of its previous cycle's CAP. Through the PERM CAP process, states are able to document actions they will take to reduce errors that cause improper Medicaid and CHIP payments. To provide ongoing oversight and assistance with the implementation of state CAPs, CPI periodically contacts states on an agreed upon schedule to obtain a status of how states are progressing with monitoring and evaluating updates during the course of a state's

implementation of their PERM CAP. If needed, a meeting is scheduled with states to provide additional guidance and technical assistance.

As a reminder, states may be subject to a disallowance if their PERM eligibility improper payment rate rises above a threshold of three percent per the PERM regulation at [42 CFR § 431.1010](#). Failure to meet CAP requirements, including the late submission of a CAP, would leave states at risk of receiving a disallowance if its future PERM eligibility improper payment rate is above the three percent threshold under [section 1903\(u\)](#) of the Act. CMS may waive this disallowance, but only if the state fulfills certain criteria that demonstrate a good faith effort to meet the three percent threshold including PERM CAP implementation in accordance with [42 CFR § 431.992](#).

For more information about the CAP process, please email PERMCAPS@cms.hhs.gov.

XIV. Recoveries

CMS expects to recover the federal share on a claim-by-claim basis related to overpayments found in error from DP review and MR. Within the PERM program, the only funds CMS can recover are from the sampled claims that contractors identified as improper payments resulting in overpayments.

Long-standing statutory and regulatory requirements govern recoveries of overpayments. The statutory and regulatory requirements for Medicaid are found under section [1903\(d\)\(2\)](#) of the Act and [42 CFR § 433 subpart F](#). Statutory and regulatory requirements for CHIP are delineated in section [2105\(c\)\(6\)\(B\) and 2105\(e\)](#) of the Act and [42 CFR § 457 subpart B](#) and 42 CFR § 457 subpart F.

Per [42 CFR § 431.1002](#), states must return to CMS the federal share of identified overpayments based on the PERM DP review and MR. For purposes of PERM, CMS considers states officially notified of identified improper payments by 1) the posting of Medicaid and CHIP FEFR reports on SMERF and 2) receiving an official letter with “notification of an overpayment” via email.

While any IV findings will not change the actual finding of the PERM review, the RC and CMS will categorize these findings as technically improper for OMB reporting purposes when the RC can independently verify that the provider would have passed the database checks. DP findings cited as technically improper as a result of the RC IV process (see the [Independent Verification of DP Reviews](#) section for more information regarding IV) will not be included on the FEFR reports because the RC was able to locate additional information to show that the provider would have been eligible if the state had taken the appropriate steps to enroll or revalidate the provider. For any findings cited as technically improper, the state is not required to recover the overpayment funds or return to CMS the federal share of the identified overpayments. An overpayment may still be assessed and included on the FEFR for recovery if an MR error and/or another DP error also exists on the claim.

The state must return the federal share on a claim with an overpayment error within one year from the date the RC submits FEFR reports. After the RC completes all reviews (including

continued processing if applicable), it creates a FEFR report that includes a comprehensive list of all claims with overpayment errors.

Eligibility improper payments are not subject to the recoveries process outlined above for DP and MR. Currently, the eligibility disallowance process is discussed in [Section 1903\(u\)](#) of the Act and related federal regulations at [42 CFR § 431, subpart P](#).

The state may request the return of improper payments found during the measurement. SMAs have the authority to pursue recovery of overpayments for any claims cited as improper during the PERM review. The state may, at its discretion, notify providers of any errors cited during and upon conclusion of the PERM cycle. The RC does not notify providers of cited errors and will not share review results with providers if requested. Providers should contact the state PERM representative for specific guidance.

A. FEFR Report

The RC posts each state's FEFR report on SMERF at the end of the cycle, after it finalizes all findings for the state for that cycle (including continued processing). The FEFR report serves as the final list of sampled federal overpayments for which a state must return the funds to CMS for a PERM cycle and does not include technically improper DP findings. The RC officially notifies state Medicaid and CHIP Directors via email when it posts the FEFR report on SMERF. This is also sent to the state's appropriate DFO contacts. Again, states are only required to recover the federal share of the sampled amount for any overpayment errors.

B. Changes on Recoveries

The state must return the federal share on a claim with an overpayment error within one year from the date the RC submits the FEFR reports for Medicaid or CHIP, per current law. If the state fails to recover such overpayments within one year of identification, it must make an adjustment to refund the federal share of the overpayment via the CMS-64 and CMS-21 forms, as described above.

Exceptions

There are some exceptions to the requirement to return the federal share of an overpayment within one year of identification.

- **The state collects the overpayment from the provider**—If the state receives recovery of the overpayment from the provider, the one-year rule no longer applies. When the state collects the overpayment from the provider, the state must return the federal share on the next quarter-ending CMS-64 and/or CMS-21 expenditure report.
- **The state adjusts the claim to the correct amount**—The PERM program reviews claims paid or denied in each quarter of the RY, including adjustments made to the claims within 60 days of the original paid date. Thus, the RC could identify overpayments for claims where the state waited more than 60 days from the original paid date to adjust to the correct paid amount. In such instances, the state is not required to return the federal share. The state should notify the PERM State Liaison and CMS DFO contact and provide documentation

(e.g., screenshots) of the adjustment.

- **Provider successfully appeals to the state**—If a provider successfully appeals the error to an Administrative Law Judge (ALJ), the state can submit proof of the ALJ decision to the PERM State Liaison and will not need to return the federal share of the overpayment. Many states have an informal appeals process in place that is preferable and less time-consuming than a formal ALJ appeal. If an error is overturned through an informal appeal process, the state should submit documentation to the PERM State Liaison and CMS DFO contact. CMS reviews the documentation to determine whether the federal share needs to be returned.
- **Provider or state submits documentation after the cycle has ended**—After the cycle is over, when states send out recovery demand letters to providers, providers sometimes submit the outstanding medical record to the state (mostly for No Reviewable Documentation Received Error [MR1] and Document(s) Absent from Record [MR2] errors). Since this occurs after the cycle cutoff date and the allowable timeframe for documentation submission (i.e., 75 days for initial MRRs and 14 days for additional documentation requests), the claim remains an error for PERM purposes, but CMS cannot request in good faith that states return the federal share if there is sufficient proof that demonstrates the state paid the claim correctly. The state should send the documentation to the CMS PERM liaison through the PERM RC SFTP. As a reminder, please do not send PII nor PHI information through email. CMS’s PERM State Liaison and PERM appeals panel review the documentation to determine if it demonstrates the state correctly paid the claim. After a decision is made, the CMS PERM State Liaison will notify the CMS DFO contact and the state of the determination.
- **The state is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with 42 CFR § 433.318**
Overpayments involving providers who are bankrupt or out of business—For bankrupt or out of business providers, the state must comply with the documentation requirements outlined in 42 CFR § 433.318.

Any request for recoveries exceptions must be based on one of the above reasons in order for CMS to review and consider the information. CMS requests that the recoveries exceptions be submitted within three months after the publication of the FEFR. In order to submit recoveries exception requests, please contact your CMS PERM State Liaison for more information and the form required to submit the request. States should be aware that they will not receive an amended FEFR report and should contact their CMS DFO contact for more information on reconciliation of the remaining amount that needs to be returned.

Underpayments

Underpayments are not included on PERM FEFR reports and are not part of the PERM recoveries process. Typically, CMS is entitled to recoup the federal credit for overpayments regardless of whether the state has collected from the provider or not. However, CMS would not credit an underpayment until the state actually corrected and paid the underpayment, at which point the state would report it as a normal operating expense and not as an adjustment on an overpayments schedule.

XV. PERM Initiatives and Available Resources

A. Systems Workgroup

The Systems Workgroup is a collaborative group consisting of representatives from CMS, the SC, the RC, the ERC, and the states to address data issues identified in the states' most recent cycle. This group works together to identify underlying problems and discuss how those issues can be resolved before the states' next review cycle. The calls typically occur after states receive their improper payment rate reporting documentation. CMS will contact states if it identifies major issues that would impact future cycles. States are welcome to contact CMS at any time if they would like to discuss any data issues that could impact their upcoming review cycles. These calls help all parties involved to better understand what data issues should be resolved and talk through any potential fixes that could be put in place.

B. PERM Technical Advisory Group (TAG)

CMS established the PERM TAG as a forum to discuss technical and operational issues and share best practices relating to the PERM program. The TAG is currently on hold.

C. Mini-PERMs

A Mini-PERM measurement is a scaled version of PERM designed to identify Medicaid and/or CHIP improper payments. Mini-PERMs provide states an opportunity to use federal resources to review Medicaid/CHIP payments made during an off year from PERM or in a way that is out of the scope of PERM. Mini-PERMs are state-specific because the state determines aspects such as sample size, universe composition, review procedures, error definitions, etc. Mini-PERMs can focus on a smaller sample, a particular component (FFS, MC, or eligibility), a specific service type, or anything else a state may choose. Many states have expressed the desire to conduct such a review but have not been able to, primarily because of resource constraints. CMS is offering the resources necessary to conduct these measurements. CMS has reviewers, statisticians, and other resources available to assist states in conducting Mini-PERMs. CMS aims to make these measurements as flexible and non-burdensome for states as possible and, therefore, the state designs the measurement and determines which CMS resources to use.

Mini-PERMs would occur during a state's off years from PERM. Conducting Mini-PERMs during off years allows states to look at payments PERM is not currently reviewing and prevents the need to coordinate both efforts simultaneously.

Conducting Mini-PERMs is an opportunity for states to identify improper payments in state-specific areas and to develop mitigation and elimination strategies. Mini-PERMs will allow states to develop targeted corrective actions to decrease improper payments made in Medicaid and CHIP. In addition, Mini-PERMs are a corrective action strategy to focus on errors or problems identified in the CSR. Mini-PERMs are separate from PERM, and CMS will not report or release Mini-PERM results.

Findings will not cause a state's PERM sample size to go up (or down). In general, Mini-PERMs

are a strong program integrity effort without the states expending significant resources.

States interested in conducting a Mini-PERM or looking for more information can contact CMS to discuss the focus of the Mini-PERM and which CMS resources would be appropriate for the state conducting the measurement.

XVI. Appendices

A. PERM Eligibility Documentation Requirements Table

The ERC conducts case reviews on behalf of the state for PERM eligibility. The ERC will review the state's eligibility determinations, redeterminations, and/or changes to see if the state followed federal and state eligibility policies and processes in place at the time of the action under review. To support the case review, the state must provide the ERC with access to the state's eligibility system(s) through remote access to collect and review the documentation. In some cases, the state may need to provide additional documentation to the ERC. The documentation that will be provided will differ by state depending on the state's eligibility policies and verification plan.

The ERC will review the documentation for the determination, redetermination, and/or changes that made the beneficiary eligible on the DOS of the sampled claim, including the verifications conducted for that action. The following tables provide detail on what documentation must be provided to the ERC during the review process. Please note that in addition to the requirements outlined in the tables, the documentation used by the state (e.g., the electronic data source or hard copy documentation) must be in line with all applicable state and federal policy, including the state's verification plan and any COVID-19 flexibilities in place at the time of the action under review. If there is uncertainty regarding any case documentation, the ERC will discuss with the state prior to citing any findings.

Note-IV

The documentation requirements that are addressed in this document can also be considered as part of the IV process, even if the information was collected for a different purpose (e.g., SNAP determinations). Questions regarding whether other sources or types of verification can be used should be directed to the ERC. Although the ERC must continue to cite an error in insufficient documentation situations unless regulatory changes occur that redefine what constitutes an improper payment, the information resulting from IV activities will be helpful to understand the true monetary loss to state(s) and federal agencies.

Overall Documentation Requirements

Documentation	Audit Trail for Reviewers	Questions for State
<p>Signed Application / Redetermination Form</p>	<p>What PERM needs to see: The original initial application must be provided to the PERM reviewer. The original pre-populated renewal form must be provided for beneficiaries whom the state could not renew via an <i>ex parte</i> or passive renewal process. The original application or redetermination form may be electronic or hard copy but should include a record of the information the applicant submitted and the applicant’s signature under penalty of perjury.</p> <p>The type of documentation that must be maintained to verify the signature varies by the channel of the application. These channels are specified below:</p> <ol style="list-style-type: none"> 1. <i>If a paper application/redetermination form was filed:</i> A paper application/redetermination form must be signed under penalty of perjury with a handwritten signature. 2. <i>If a fax application/redetermination form was filed:</i> A fax application/redetermination form must be signed under penalty of perjury with a handwritten signature. 3. <i>If an electronic application/redetermination form was filed:</i> An electronic application/redetermination form must be signed under penalty of perjury with an electronic signature. <p><i>An example of an electronic signature:</i></p> <p>Electronic Signature</p> <p>By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and under penalty of perjury, I certify the information I have given is true including the information concerning citizenship and alien status. I have received information on how to apply, what information is available, and what I may need to give the county to help me with getting benefits.</p> <p><input checked="" type="checkbox"/> By checking this box and typing my name below, I am electronically signing my application.</p> <p>Person’s name and date</p>	<ul style="list-style-type: none"> • How are original applications and/or redetermination forms maintained in your state? How will they be made available to the PERM reviewers? • For each type (e.g., paper, electronic) and channel (e.g., in-person, online, phone) of application, how are signatures maintained in your state? How will they be made available to PERM reviewers?

Documentation	Audit Trail for Reviewers	Questions for State
	<p>4. <i>If a phone application/redetermination form was filed:</i> A phone application/redetermination form must be signed under penalty of perjury with a telephonically recorded signature. The audio file or written transcript documenting the telephonically recorded signatures must be provided to PERM reviewers. The ERC must be able to listen to the full audio recording of the phone application and the recorded signature.</p> <p>Signatures and redetermination forms are not required on passive or <i>ex parte</i> renewals.</p>	
<p>Electronic Verification</p>	<p>What PERM needs to see: If the state used electronic verification to verify the element, there should be an indicator in the eligibility system showing that the eligibility element was verified, including the result of the verification and when the verification took place, for the action under review. For system indicators to be acceptable, they must be automatically generated and unable to be altered. Indicators manually updated are not acceptable proof of electronic verification. If a state verifies income electronically but a verification indicator is not viewable in the system, the state can work with the ERC to provide the information through a system-generated, backend report. The ERC must be able to determine whether the verification occurred as part of the action under review.</p> <p>Notes: States may not use electronic verifications for the elements listed below in all instances. Further, some of the elements in the examples are not verified at redetermination.</p> <p><u>Examples of acceptable indicators within an eligibility system:</u></p> <p>1. The state’s eligibility system displays information that the electronic data match occurred.</p> <p><i>An example of a display:</i></p>	<ul style="list-style-type: none"> • Does the state have indicators in your eligibility system for all electronic verifications? If not, how does the state know that the electronic verification occurred and showed that the beneficiary was eligible? • How will PERM reviewers be able to determine that the electronic verification is related to the action under review? • Please describe what indicators will be available in the state system for each element of eligibility listed in this table. • Will the PERM reviewers be able to determine when the verification occurred based

Documentation	Audit Trail for Reviewers	Questions for State																
	<p data-bbox="579 228 1430 293"> Income records used to determine eligibility have been verified by a trusted data source</p> <p data-bbox="541 318 1402 418">2. The state’s eligibility system contains a separate verification page for each eligibility decision. The verification page lists the verification element and the verification status.</p> <p data-bbox="569 440 1262 472"><i>An example of a verification page with pass/fail status:</i></p> <table border="1" data-bbox="569 505 1142 675"> <thead> <tr> <th data-bbox="569 505 932 529">Verification Element</th> <th data-bbox="932 505 1142 529">Verification Status</th> </tr> </thead> <tbody> <tr> <td data-bbox="569 553 932 578">Citizenship</td> <td data-bbox="932 553 1142 578">Pass</td> </tr> <tr> <td data-bbox="569 602 932 626">SSN</td> <td data-bbox="932 602 1142 626">Pass</td> </tr> <tr> <td data-bbox="569 651 932 675">Income</td> <td data-bbox="932 651 1142 675">Fail</td> </tr> </tbody> </table> <p data-bbox="569 691 1402 724"><i>An example of a verification page with verified/not verified status:</i></p> <table border="1" data-bbox="569 756 1142 927"> <thead> <tr> <th data-bbox="569 756 932 781">Verification Element</th> <th data-bbox="932 756 1142 781">Verification Status</th> </tr> </thead> <tbody> <tr> <td data-bbox="569 805 932 829">Citizenship</td> <td data-bbox="932 805 1142 829">Verified</td> </tr> <tr> <td data-bbox="569 854 932 878">SSN</td> <td data-bbox="932 854 1142 878">Verified</td> </tr> <tr> <td data-bbox="569 902 932 927">Income</td> <td data-bbox="932 902 1142 927">Not Verified</td> </tr> </tbody> </table>	Verification Element	Verification Status	Citizenship	Pass	SSN	Pass	Income	Fail	Verification Element	Verification Status	Citizenship	Verified	SSN	Verified	Income	Not Verified	<p data-bbox="1514 228 1881 293">on the information available in the system?</p> <p data-bbox="1463 318 1881 675">Note: For states that verify self-attested income against the IRS as the sole source for income verification, the ERC must not view or obtain that information. The ERC will communicate a modified approach for retrieving verifications from these states to prevent disclosure of this protected information.</p>
Verification Element	Verification Status																	
Citizenship	Pass																	
SSN	Pass																	
Income	Fail																	
Verification Element	Verification Status																	
Citizenship	Verified																	
SSN	Verified																	
Income	Not Verified																	
<p data-bbox="247 967 415 1065">Electronic Verification (continued)</p>	<p data-bbox="541 959 1453 1016">The state’s eligibility system contains a check box where a check appears when a data match occurred.</p> <p data-bbox="569 1040 926 1073"><i>An example of a check box:</i></p> <p data-bbox="600 1105 1010 1154">Citizenship / Identity validated by SSA? <input checked="" type="checkbox"/></p> <p data-bbox="541 1195 1262 1260">3. The state’s eligibility system provides more detailed information related to the electronic data match.</p> <p data-bbox="541 1284 1262 1349"><i>Examples of indicators that contain detailed information about the electronic data match:</i></p>																	

Documentation	Audit Trail for Reviewers	Questions for State																												
	<p>Verification Information for ID=DHSIncomeVerified</p> <table border="1"> <thead> <tr> <th>Indicator</th> <th>Category Code</th> <th>Response Code</th> <th>Authority Name</th> <th>Authority Alpha Code</th> <th>Date</th> <th>Verification Req System</th> </tr> </thead> <tbody> <tr> <td>✓</td> <td>CurrentIncome</td> <td>HS000000</td> <td></td> <td>State</td> <td>01/04/2016-09:23:52AM</td> <td>Exchange System Category Code MedicaidAgency</td> </tr> </tbody> </table> <p>Verification Information for ID=SOM1HUB104170729SSA</p> <table border="1"> <thead> <tr> <th>Indicator</th> <th>Category Code</th> <th>Response Code</th> <th>Authority Name</th> <th>Authority Alpha Code</th> <th>Date</th> <th>Verification Requesting System</th> </tr> </thead> <tbody> <tr> <td>✓</td> <td></td> <td>HS000000</td> <td></td> <td>SSA</td> <td>01/04/2016-05:07:29PM</td> <td>Exchange System Category Code State Code</td> </tr> </tbody> </table>	Indicator	Category Code	Response Code	Authority Name	Authority Alpha Code	Date	Verification Req System	✓	CurrentIncome	HS000000		State	01/04/2016-09:23:52AM	Exchange System Category Code MedicaidAgency	Indicator	Category Code	Response Code	Authority Name	Authority Alpha Code	Date	Verification Requesting System	✓		HS000000		SSA	01/04/2016-05:07:29PM	Exchange System Category Code State Code	
Indicator	Category Code	Response Code	Authority Name	Authority Alpha Code	Date	Verification Req System																								
✓	CurrentIncome	HS000000		State	01/04/2016-09:23:52AM	Exchange System Category Code MedicaidAgency																								
Indicator	Category Code	Response Code	Authority Name	Authority Alpha Code	Date	Verification Requesting System																								
✓		HS000000		SSA	01/04/2016-05:07:29PM	Exchange System Category Code State Code																								
<p>Case Comments</p>	<p>What PERM needs to see: States may utilize case comments or caseworker narratives to document certain eligibility actions. The case comment should provide enough detail for the ERC to substantiate the action, if needed.</p> <p><u>Example of level of detail in case comments:</u> The beneficiary (Name) called to update monthly income due to a new job. Current monthly income is now \$1000 as of [Date]. Earned income was verified by TALX on [Date]. Monthly income is \$1200. Reasonable compatibility check was done on [Date] using [electronic data source].</p>	<ul style="list-style-type: none"> • Do case workers use case comments to document any eligibility actions? If so, which ones? • What level of detail is provided in the case comments? • Do the comments support the evidence available in the system at the time of the action under review? 																												

Documentation Requirements for Eligibility Criteria (Element)

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
Citizenship	<p>What PERM needs to see: An indicator or hard copy documentation showing that citizenship or status as a U.S. national was appropriately verified at the time of initial determination. (Note: The ERC will not re-review citizenship verification for renewals unless there is indication that it was not completed previously.)</p> <p><i>If verified electronically:</i></p> <p>There must be an indicator in the eligibility system associated with the action under review showing that citizenship was verified per federal requirements.</p> <p><i>If verified via hard copy documentation:</i></p> <p>The state must have a record of the hard copy documentation used. Examples of allowable hard copy documentation might include:</p> <ol style="list-style-type: none"> 1. U.S. Passport. 2. Certificate of Naturalization. 3. Certificate of U.S. Citizenship. 4. A valid, State-issued driver's license, in some states. 5. Birth Certificate. 6. U.S. State Vital Statistics. 	<ul style="list-style-type: none"> • What will reviewers see in your state? • What indicators are in your state's system for electronic verification of citizenship? Is the electronic data source used for verification shown? Is the result of the verification clear? • What hard copy documentation does your state accept? How is it maintained/stored? How can it be made available to reviewers?

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
Immigration Status/ Non-citizens	<p>What PERM needs to see: An indicator or hard copy documentation showing that immigration status was appropriately verified at the time of determination or redetermination.</p> <p><i>If verified electronically:</i></p> <p>There must be an indicator in the eligibility system associated with the action under review showing that immigration status was verified, or a scanned copy of a Systematic Alien Verification for Entitlements (SAVE) Report may be maintained in the system.</p> <p><i>If verified via hard copy documentation:</i></p> <p>The state must have a record of the hard copy documentation used. Examples of allowable documentation (copies permitted) include:</p> <ol style="list-style-type: none"> 1. Permanent Resident Card. 2. Refugee or Asylee documentation. 	<ul style="list-style-type: none"> • What will reviewers see in your state? • What indicators are in your state's system for electronic verification? Is the electronic data source used for verification shown? Is the result of the verification clear? <p>What hard copy documentation does your state accept? How is it maintained/stored? How can it be made available to reviewers?</p>

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
State Residency	<p><u>If self-attestation accepted:</u> If self-attestation is accepted per the state’s verification plan, the state must produce a signed application or redetermination form, if applicable, with the beneficiary’s residency indicated on the form to verify self-attestation.</p> <p><u>If self-attestation not accepted:</u> <u>If verified electronically:</u> There must be an indicator in the eligibility system associated with the action under review showing state residency was verified using third party sources. If the state’s verification plan identifies the sources that the state will use to verify residency, the indicator should show that those sources were used.</p> <p><u>If verified via hard copy documentation:</u> The state must have a record of the hard copy documentation used. Examples of allowable hard copy documentation include:</p> <ol style="list-style-type: none"> 1. Property ownership records. 2. Rent or mortgage receipt. 3. Current state ID card or driver's license. 4. Utility bills or bank statements from third party sources. 5. Property tax receipts. 	<ul style="list-style-type: none"> • Does your state accept self-attestation? • If so, is the self-attestation clearly available on the original application or redetermination form? • If not, what documentation is maintained to verify state residency? • What indicators are in your state’s system for electronic verification, if required, for state residency in your state? Is the electronic data source used for verification shown? Is the result of the verification clear? • What hard copy documentation does your state accept? How is it maintained? How can it be made available to reviewers?
SSN	<p>What PERM needs to see: An indicator or hard copy documentation showing that the SSN was appropriately verified at the time of determination or after enrollment, if the state conducts Post-Enrollment Verification (PEV).</p> <p><u>If verified electronically:</u> There must be an indicator in the eligibility system associated with the action under review showing SSN was verified by the Social Security Administration.</p> <p><u>If verified via hard copy documentation:</u></p>	<ul style="list-style-type: none"> • What will reviewers see in your state? • What indicators are in your state’s system for electronic verification? Is the electronic data source used for verification shown? Is the result of the verification clear? • What hard copy

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
	<p>The state must have a record of the hard copy documentation used. Examples of allowable hard copy documentation include but are not limited to:</p> <ol style="list-style-type: none"> 1. Social Security Card. 2. W-2, 1099 or other tax forms issued to the individual. 3. Proof that the issuance of the SSN is pending. 	<p>documentation does your state accept? How is it maintained/stored? How can it be made available to reviewers?</p>
<p>Age/Date of Birth</p>	<p><u>If self-attestation accepted:</u> If self-attestation is accepted per the state’s verification plan, a signed application can be utilized to verify self-attestation.</p> <p><u>If self-attestation not accepted:</u> There must be an indicator in the eligibility system associated with the application showing the date of birth was verified using third party sources. If the state’s verification plan identifies the sources that the state will use to verify age/date of birth, the indicator should show that those sources were used. There are instances where age is verified electronically as part of social security and identification elements. <i>(See Table 2 for electronic verification requirements.)</i></p> <p><u>If verified via hard copy documentation:</u> The state must have a record of the hard copy documentation used. Examples of allowable hard copy documentation include:</p> <ol style="list-style-type: none"> 1. Birth Certificate. 2. U.S. State Vital Statistics record. 3. Hospital Birth Records. 	<ul style="list-style-type: none"> • Does your state accept self-attestation? • If so, is this information clearly available on the application? • If not, what will reviewers see in your state? • What indicators are in your state’s system for electronic verification? Is the electronic data source used for verification shown? Is the result of the verification clear? • What hard copy documentation does your state accept? How is it maintained/stored? How can it be made available to reviewers?
<p>Pregnancy</p>	<p>States must accept self-attestation for pregnancy. A signed application or redetermination form or other self-attested means where the beneficiary indicated pregnancy status can be used to verify self-attestation. Pregnancy self-attestation can also be documented by appropriately documented case notes.</p>	<ul style="list-style-type: none"> • Is this information clearly available on the application or redetermination form?

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
Household Size	<p><u>If self-attestation accepted:</u></p> <p>If self-attestation is accepted per the state’s verification plan, a signed application or redetermination form can be utilized to verify self-attestation. Appropriately documented case notes are also an acceptable form of self-attestation if allowable by the state.</p> <p><u>If self-attestation not accepted:</u></p> <p><i>If verified electronically:</i></p> <p>There must be an indicator in the eligibility system associated with the action under review showing household size was verified as specified in the state’s verification plan.</p> <p><i>If verified via hard copy documentation:</i></p> <p>The state must provide the hard copy documentation used. Examples of allowable hard copy documentation include but are not limited to:</p> <ol style="list-style-type: none"> 1. Birth certificates. 2. Adoption papers or records. 3. Marriage licenses. 4. Divorce papers. 5. Court records of parentage. 	<ul style="list-style-type: none"> • Does your state accept self-attestation? • If so, is this information clearly available on the application or redetermination form? • If not, what will reviewers see in your state? • What indicators are in your state’s system for electronic verification? Is the electronic data source used for verification shown? Is the result of the verification clear? • What hard copy documentation does your state accept? How is it maintained/stored? How can it be made available to reviewers?

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
Blindness, Disability, Medical Eligibility/LOC	<p><u>If determined by State agency:</u></p> <p>The state must provide the state-specific Medical Review Team (MRT), or other authorized entity’s approval form or a comparable system screen(s) that shows information regarding approval, decision date, and other relevant details.</p> <p><u>If determined by the Social Security Administration:</u></p> <p>The state must provide PERM reviewers proof that the beneficiary was enrolled in the program for which the disability or blindness determination was determined at the action under review.</p> <p>Examples include hard copy documentation or electronic proof of enrollment in the program for which disability or blindness was determined. Examples of allowable hard copy documentation includes:</p> <ol style="list-style-type: none"> 1.Receipt of RSDI or SSI (benefits on the basis of disability) as of the DOS. 2.Award Letters. 	<ul style="list-style-type: none"> • Are you a 1634 state? • If so, how can reviewers see that the individual was enrolled in RSDI, SSI, etc.? • If not, where do you store blindness/disability determinations? Is it available in the case record? • How will medical eligibility/LOC documentation be made available to the reviewer?
Earned and Unearned Income **Please Note: The ERC will communicate further guidance to the state if the AT file contains electronic-	<p>What PERM needs to see: An indicator or hard copy documentation showing that earned and unearned income was appropriately verified for the action under review.</p> <p><u>If verified electronically:</u></p> <p>The state must provide the verification screen with the income amount and the dates associated with the amount, or a system generated indicator in the eligibility system associated with the action under review showing income was reasonably compatible using third party sources identified in the state’s verification plan.</p> <p>If the verification screens show income information derived from the IRS, the ERC will request a written statement from the state that validates income was verified correctly or incorrectly for the determination date.</p> <p><u>If verified via hard copy documentation:</u></p>	<ul style="list-style-type: none"> • What will reviewers see in your state? • Does your state verify income pre- or post-eligibility? If so, what is the time frame during which the verification must be made? • In what situations is your state not utilizing electronic data sources to verify income? • What indicators are in your state’s eligibility system(s) for electronic verification? Is the electronic data source used for

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
<p>ally verified self-attested income against IRS data only.</p>	<p>The state must provide the hard copy documentation used for each income type or case notes indicating what documentation was used and the amounts that were indicated.</p> <p>Documentation must be available for each type of income including, but not limited to, the following:</p> <ul style="list-style-type: none"> • Wages and Salaries. • Self-employment income. • RSDI. • Unemployment wages. • Veteran’s Benefits (Non-MAGI). • Worker’s Compensation Benefits (Non-MAGI). • Child Support (Non-MAGI). • Other Earned Income (tips, bonuses, commission, severance pay). • Other Unearned Income (rental income, pension income, trust income). 	<p>verification shown? Is the result of the verification clear? Is the time frame for the verification clear?</p> <ul style="list-style-type: none"> • Are there any electronic verification sources that reviewers cannot have access to? • What hard copy documentation does your state accept? How is it maintained/stored? How can it be made available to reviewers? • Are there any types of income that are handled differently?
<p>Resources / Assets (Non-MAGI cases)</p>	<p>What PERM needs to see: An indicator or hard copy documentation showing that resources/assets were appropriately verified, if applicable, for the action under review.</p> <p><i>If verified electronically:</i></p> <p>There must be an indicator, documentation from the asset verification system, or detailed case comments to indicate that electronic verification was performed.</p> <p><i>If verified via hard copy documentation:</i></p> <p>The state must provide the hard copy documentation used.</p> <p>Documentation must be available for each type of resource/asset including, but not limited to, the following:</p>	<ul style="list-style-type: none"> • Does your state have an Asset Verification System (AVS) or have plans to implement an AVS in the future? Is the time frame for the verification clear? • What indicators are in your state’s eligibility system for electronic verification? Is the electronic data source used for verification shown? Is the result of the verification clear? • What hard copy

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
	<ul style="list-style-type: none"> • Bank Accounts/Financial Resources. • Property. • Vehicle. • Trusts/Annuities. • Life Insurance. • Funeral/Burial Trusts/Plots. 	<p>documentation does your state accept? How is it maintained/stored? How can it be made available to reviewers?</p> <ul style="list-style-type: none"> • Are there situations in which the state accepts self-attestation of resources for renewals?
<p>TPL (e.g., Private Health Insurance)</p>	<p>What PERM needs to see: An indicator or hard copy documentation showing that health insurance was appropriately verified, if applicable, for the action under review.</p> <p><i>If self-attestation accepted:</i></p> <p>If self-attestation is accepted per the state’s verification plan, a signed application or redetermination form can be utilized to verify self-attestation.</p> <p><i>If self-attestation not accepted:</i></p> <p><i>If verified electronically:</i></p> <p>There must be an indicator in the eligibility system or information specific to a health plan indicating the type of health coverage, the individuals covered, and the coverage period.</p> <p><i>If verified via hard copy documentation:</i></p> <p>The state must provide the hard copy documentation used.</p>	<ul style="list-style-type: none"> • How does your state verify health insurance when appropriate? • How does your state follow-up on discrepant information (e.g., beneficiary self-attests to not having TPL; however, wage verification documentation shows health insurance deductions)?

Other Documentation Requirements

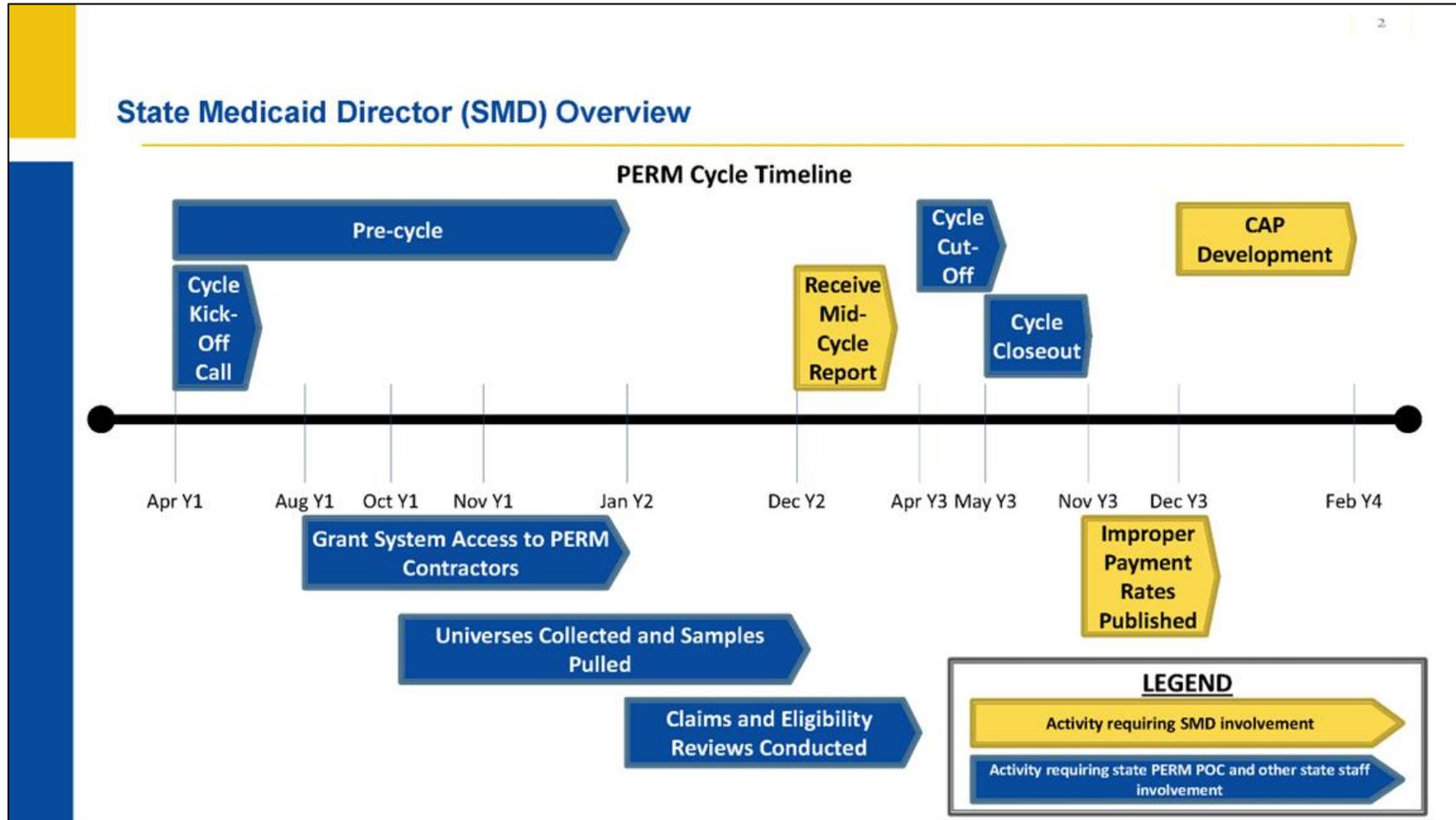
Item	Audit Trail for Reviewers	Questions for State
Passive Renewals	<p>What PERM needs to see: If a passive renewal occurred, indicators showing that the eligibility system verified income and other eligibility elements that must be re-verified at renewal (refer to the Electronic Verification row in the Overall Documentation Requirements table above).</p> <p>Similar to initial applications and redeterminations, the state must be able to show the eligibility system verified income and other required eligibility elements through electronic sources (e.g., indicator in the system).</p>	<ul style="list-style-type: none"> • How can PERM reviewers identify passive renewals in your state? • What verification indicators will reviewers see in your state for passive renewals?
Tax Filer Status	<p>What PERM needs to see: The applicant reported being a tax filer. (Note: If there is not a tax filer status, the non-tax filer rules would apply.)</p> <p>States must maintain evidence that all MAGI applicants were asked about their tax filing status (e.g., application), and all other documentation used to determine household composition in accordance with 42 CFR § 435.603(f).</p>	<ul style="list-style-type: none"> • How does the state ask for tax filing status and how can this documentation be provided to the reviewers?
Reported Changes by Beneficiary	<p>What PERM needs to see: Documentation of any changes submitted by the beneficiary, including when the changes were communicated to the state, as well as how and when the state acted on the change, if required.</p> <p>Note: The ERC reviews the last full determination or redetermination prior to the DOS of the claim as well as all changes between that full determination or redetermination and the DOS.</p>	<ul style="list-style-type: none"> • What will reviewers see in your state when a beneficiary reports changes? • How does your state document beneficiary -reported changes? • How will reviewers be able to determine whether a full redetermination occurred (i.e., all required elements were reviewed, and the renewal date was extended)?
Title IV-E Cases	<p>What PERM needs to see: Electronic or hard copy documentation showing that the individual was enrolled in Title IV-E benefits that entitles the beneficiary to Medicaid at the time of the DOS of the sampled claim. The ERC will not review the underlying Title IV-E eligibility</p>	<ul style="list-style-type: none"> • What documentation can the state provide to the reviewers to show that the beneficiary was enrolled in Title IV-E?

Item	Audit Trail for Reviewers	Questions for State
	<p>determination.</p> <p><u>Examples of Title IV-E documentation:</u></p> <ol style="list-style-type: none"> 1. State form providing information regarding the Title IV-E decision and the benefit period of Title IV-E and should document when the state received the form. 2. Screen prints of state system showing the beneficiary was receiving Title IV-E benefits. 	
<p>SSI Cases – 1634 states</p>	<p>What PERM needs to see: If a state is a 1634 state, electronic or hard copy documentation showing that the individual was eligible for SSI as of the DOS of a sampled claim. The ERC will not review the underlying SSI eligibility determination.</p> <p><u>Examples of documentation for SSI decisions of 1634 states:</u></p> <ol style="list-style-type: none"> 1. Screen prints of state system showing the beneficiary was receiving SSI benefits and when the state received notification of the decision made by SSA. 2. Data notification from SSA. 3. Beneficiary Data Exchange (BENDEX) system record. 	<ul style="list-style-type: none"> • Is your state a 1634 state? • If yes, what documentation will your state be able to provide to the reviewers to show beneficiary enrollment in SSI?
<p>Presumptive Eligibility by Qualified Entities</p>	<p>What PERM needs to see: Documentation showing that the state received information from qualified entity to enroll the individual.</p> <p><u>Presumptive eligibility documentation may include:</u></p> <ol style="list-style-type: none"> 1. Correspondence and notifications between the state and the qualified entity and when the state received the notification. 	<ul style="list-style-type: none"> • What presumptive eligibility documentation is sent to the state by the qualified entity? • How is the information stored in your state and how can it be provided to reviewers?
<p>Cases from the FFE</p>	<p>What PERM needs to see: The AT file or another document showing the original information in the AT file if maintained by the state.</p> <p>The AT file will only be requested for FFE-A and FFE-D cases where the action under review is the determination made by the FFE or involved use of the FFE’s assessment of the applicant’s information.^{i,ii}</p>	<ul style="list-style-type: none"> • Are AT-files maintained by the state? If so, for what period of time? • In what format are the AT files maintained? • Who maintains the AT files in your state?

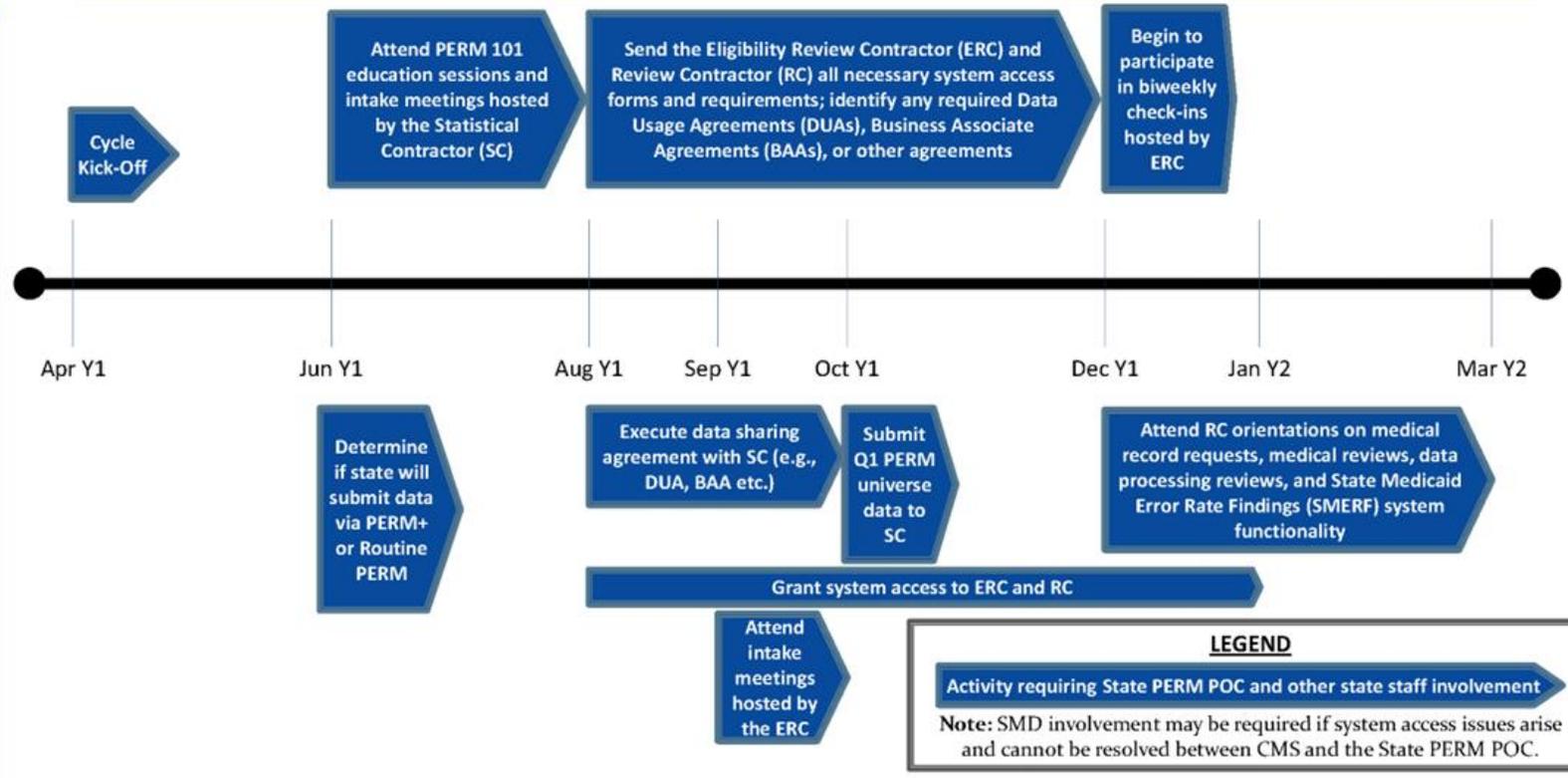
ⁱ The ERC will communicate further guidance to the state if the AT file contains electronically verified self-attested income against IRS data only

ii Process is subject to change during the cycle. CMS and the ERC will update the process and notify the states accordingly

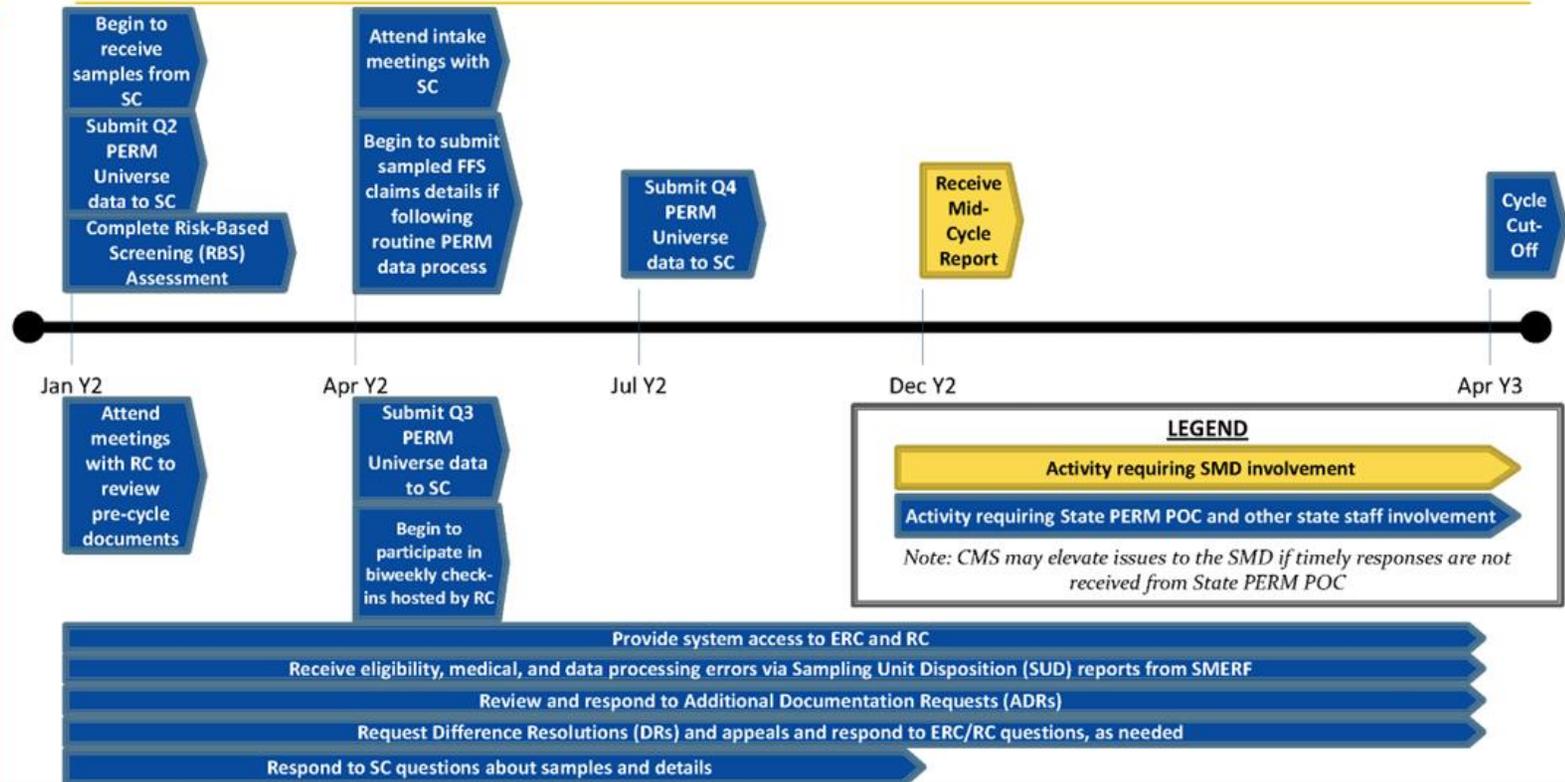
B. PERM Timeline



State PERM Team Pre-Cycle



State PERM Team Case Review Cycle



State PERM Team Cycle Close

