RY 2028 Contractor Roles and Responsibilities

RY 2028 Statistical Contractor (SC) – The Lewin Group – Responsible for Sample Selection, Populating Claims, and Improper Payment Rate Calculation

Each quarter throughout the fiscal year, the SC collects the universe of claims data for Medicaid and Children's Health Insurance Program (CHIP) Fee-For-Service (FFS) and managed care from the states. The universe includes claims that are matched with Title XIX (Medicaid) or Title XXI (CHIP) Federal Financial Participation (FFP), including payments made outside of the state's Medicaid Management Information System (MMIS).

The SC draws a random sample of claims from the quarterly Medicaid FFS, CHIP FFS, Medicaid managed care, and CHIP managed care universes submitted by the states. There are also state-specific sample sizes based on the prior cycle improper payment rates and margin of error, as well as state expenditures, with a sample size cap for Medicaid (1,800 FFS, 200 managed care, and 1,200 eligibility) and CHIP (1,080 FFS, 120 managed care, and 800 for eligibility). Since claims data is submitted quarterly by the states, each quarter is treated as a separate universe and sampled accordingly. After drawing the samples, the SC sends the samples to the PERM Review Contractor (PRC) and the state.

For routine PERM states, the FFS sample list contains minimum data information so the states must provide enhanced information on the sampled FFS claims (submitting details). After the samples are populated and returned to the SC, the SC standardizes the format of the claims data and sends it to the PRC for medical records requests. For PERM+ states, enhanced information is submitted in the original universe, and the SC sends claims data to the PRC for medical records request without the need for states to populate the sample.

To ensure that states have submitted the entire universe of claims and payments for services provided to individual beneficiaries, the SC compares each state's PERM universe data to the state's CMS-64 and/or CMS-21 reports. If the dollars submitted for the PERM universes are substantially different than what the state reported on the same quarter's CMS-64 and/or CMS-21 reports, the SC is required to identify reasons for the discrepancy in order to ensure that the state submitted all claims subject to sampling and review according to the PERM regulation and guidance.

At the end of the PERM process, the SC calculates state-specific and national Medicaid and CHIP improper payment rates overall and by component.

RY 2028 PERM Review Contractor (PRC) – Booz Allen Hamilton (BAH) – Responsible for Policy Collection, Medical Records Requests (MRR), Medical Reviews (MR), Eligibility Reviews (ER), Data Processing (DP) Reviews, Federal Medicaid Assistance Percentage (FMAP) Assignments, and Maintenance of the State Medicaid Error Rate Findings (SMERF) System

The PRC is responsible for obtaining, organizing, and maintaining federal and state policies for the PERM program by working with states and CMS to gather public and non-public policy information. This ensures the PRC is familiar with policies for MR, ER and DP reviews in each state (policy content and application, location, and format) prior to beginning the PERM review process.

When the PRC receives the claims **details** files for the sampled claims from the SC, the PRC begins sending MRR to providers. The PRC's customer service representatives will contact providers associated with the sampled FFS claims to obtain copies of the medical records. Providers have 75 calendar days to send copies of medical records for the selected claim. If the provider does not respond, the state is notified of an error due to no documentation.

Once the records are received, the PRC performs MR on the sampled FFS claims. The PRC examines the medical record to ensure there is documentation that supports the good(s) or service(s) were: covered according to Medical Assistance Programs and State Children's Health Insurance Programs (CHIP) federal regulations, state policy, medically necessary, and coded accurately. If the record does not contain sufficient documentation, the provider has 14 calendar days to provide the missing documentation. Errors are cited for reviews with missing documentation. The PRC will accept additional documentation submitted by the state in support of case reviews through the end of the cycle for MR1s or MR2s and will update error findings when appropriate. Managed care claims are not subject to MR because there is no specific service rendered on which to make a medical necessity determination.

When the PRC receives the **sample** files from the SC, the PRC begins collecting documentation from state systems for each sampled claim for ER and DP reviews.

- ER for FFS and Managed care claims include viewing state eligibility determinations that made individuals eligible on the Date of Service (DOS) for each claim payment sampled.
- DP reviews for FFS sampled claims include examining line items of each claim to validate that it was processed correctly.
- DP reviews for Managed Care sampled claims include checking the accuracy of the processing of the capitation payment or premium.

If the ER or DP review case file does not contain sufficient documentation to support a C1 finding, states have 30 calendar days to provide missing documentation for eligibility via the EP1 request and 14 calendar days for DP reviews via the P1 request in SMERF. The PRC will accept additional documentation submitted by the state in support of case reviews through the end of the cycle for both ER errors (i.e., ER1, ER2, ER3) and DP errors (i.e., DP1, DP2, and DP3) and will update error findings when appropriate.

With the state's confirmation, the PRC will map the state eligibility categories to a federal eligibility category and an FMAP rate. These FMAP rates are used to identify federal dollars assigned to a claim for each type of PERM review based on Category of Eligibility and Date of Service.

The findings of the MR, ER and DP reviews are posted to the PRC's secure website, SMERF, which can be reviewed by each state. States may monitor error citations in SMERF. If a state disagrees with an error, a Difference Resolution (DR) may be requested in SMERF within 25 business days of the error posting to the Sampling Unit Disposition (SUD) report during the month. If a state disagrees with the DR decision, an appeal request may be filed in SMERF within 15 business days of the DR decision. CMS will make the final appeal decision.

After the review cycle ends, the PRC sends the full set of detailed findings for all review types to the SC for use in the improper payment calculations.