



Payment Error Rate Measurement (PERM)



Introduction to PERM
May 2026

*Centers for Medicare & Medicaid
Services*

Agenda

- PERM Overview
- PERM Methodology Overview
- Roles and Responsibilities
- Differences Between RY 2025 and RY 2028 Cycles
- SC Process Details
- PRC Process Details
- Overview of Review Types
- Best Practices
- Communication and Collaboration
- Contact Information

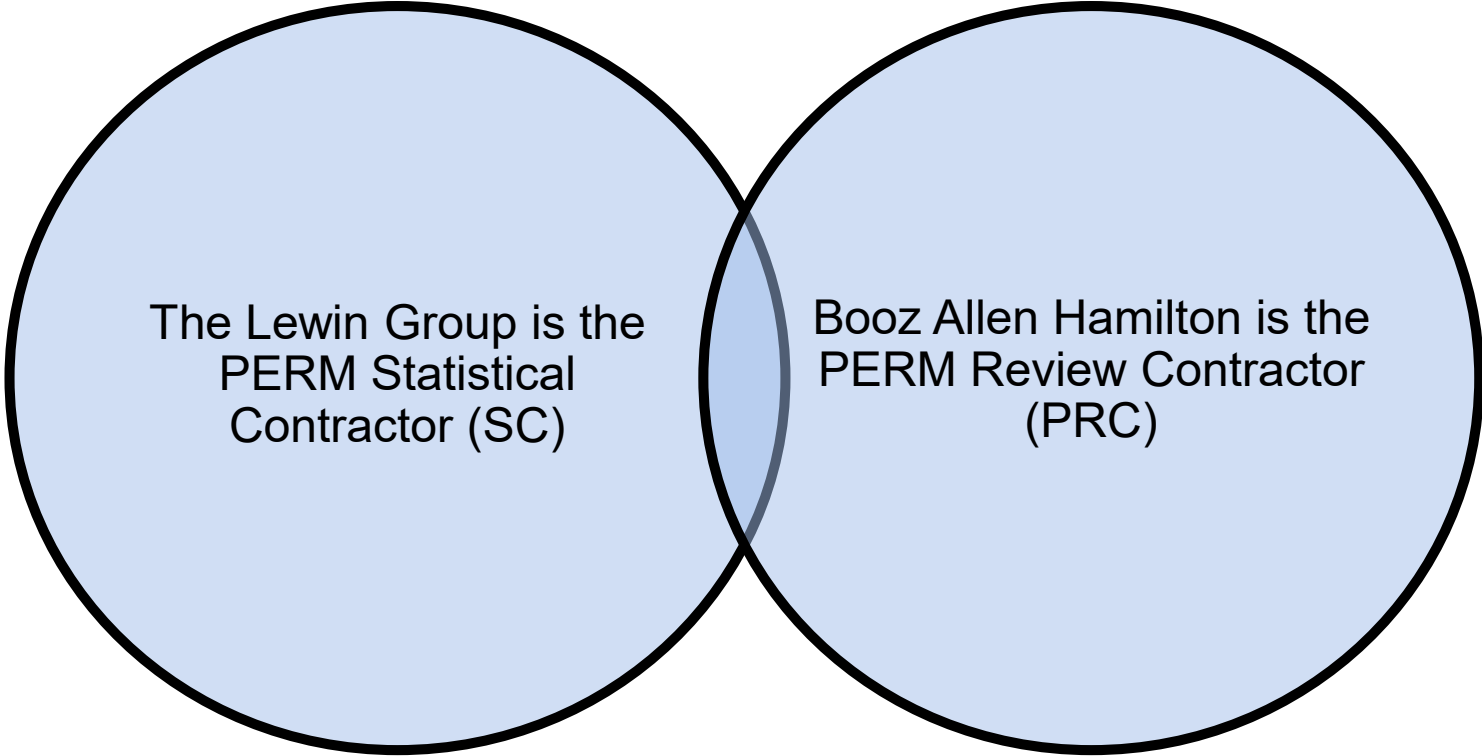


PERM Overview

Legal Basis for Measuring Medicaid and CHIP Improper Payments

- The PERM program measures and reports a national improper payment rate for Medicaid and the Children's Health Insurance Program (CHIP) to comply with the requirements of the Payment Integrity Information Act (PIIA) of 2019.

PERM Contractors

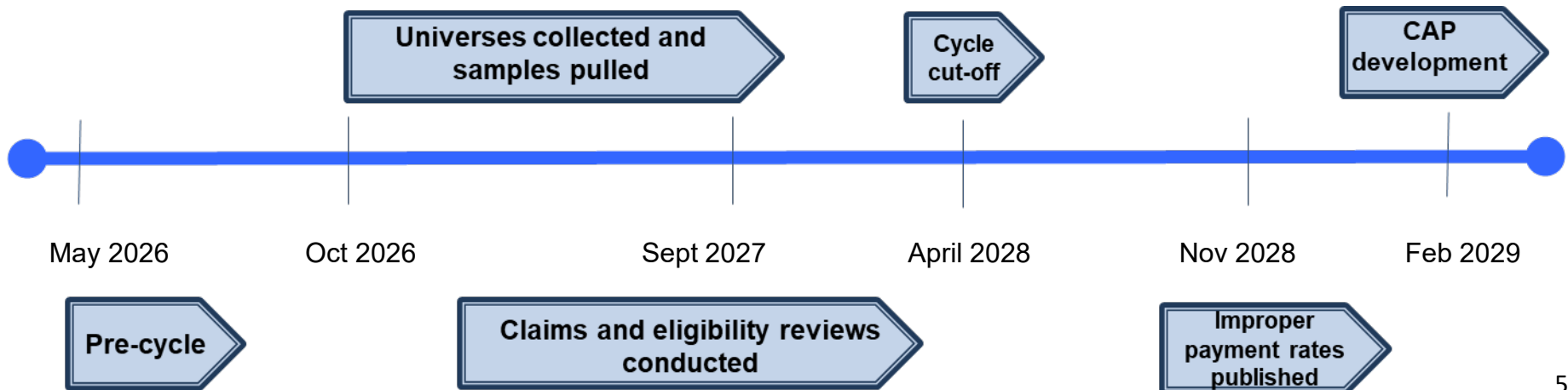


The Lewin Group is the
PERM Statistical
Contractor (SC)

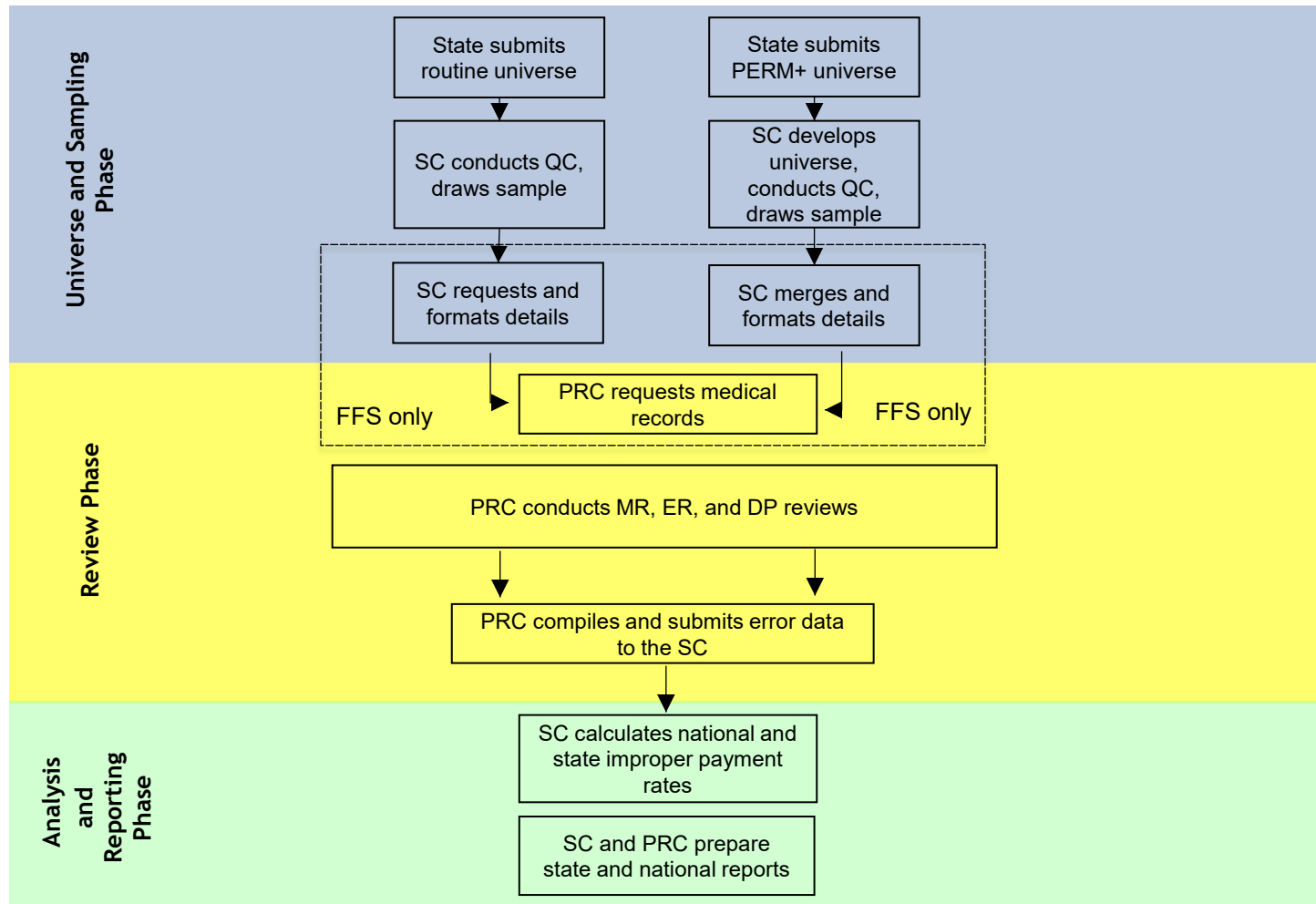
Booz Allen Hamilton is the
PERM Review Contractor
(PRC)

- Process of sampling, reviewing payments, and calculating and reporting improper payment rates takes more than 2 years.
- Fee-for-service (FFS) claims and managed care capitation payments are collected for a full year – July 1, 2026 through June 30, 2027.
 - Sampled payments can receive a medical review (MR), eligibility review (ER), and/or data processing (DP) review.
 - Findings are used to calculate improper payment rates.
 - States receive findings and develop a Corrective Action Plan (CAP).

Ry 2028 PERM Cycle Timeline



Routine PERM vs. PERM+





PERM Methodology Overview

Measuring Payment Errors in Medicaid and CHIP

- The goal of PERM is to measure and report an unbiased estimate of the true improper payment rate for Medicaid and CHIP.
- Because it is not feasible to verify the accuracy of every Medicaid and CHIP payment, CMS uses a statistically valid methodology that samples a small subset of payments, then extrapolates to the “universe” of payments.
- PERM uses a two-stage sampling approach:
 - CMS uses a 17- or 18-state rotation per cycle (each state is reviewed once every 3 years).
 - From within each state, district, or territory, a stratified random sample of payments is selected.
 - The sampled payments are reviewed for errors.
 - CMS uses the findings to estimate a national improper payment rate.

Measuring Payment Errors in Medicaid and CHIP (cont'd)

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

PERM State/District/Territory Rotation

Cycle	Medicaid and CHIP States Measured by Cycle
Cycle 1 (RY28)	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2 (RY26)	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 3 (RY27)	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, Puerto Rico, South Dakota, Texas, Washington

PERM Review Types and Sample Sizes

- PERM samples are selected from distinct universes for two programs:
 - Programs: Medicaid (Title XIX) and CHIP (Title XXI).
 - Universes: FFS and Managed Care.
- Claims selected from the FFS universe are subject to as many as three different reviews:
 - DP, MR, and ER.
- Payments selected from the managed care universe are subject to as many as two different reviews:
 - DP and ER.
- PERM will use a cycle sample size each year that caps the number of samples selected from FFS and managed care for each review type.
- The cycle sample size will be distributed across states based on their latest expenditures and improper payment results.
- All review results are reported via the State Medicaid Error Rate Findings (SMERF) system, a web-based application hosted by the PRC.



Roles and Responsibilities

CMS PERM Team Responsibilities

- Program Oversight and Support:
 - Structure the parameters for measurement through legal and policy decision-making processes.
 - Oversee the operation of PERM and PERM contractors to ensure that CMS meets its regulatory requirements.
 - Ensure the measurement remains on track and work with states when challenges occur.
- Communication and Information Sharing:
 - Host monthly cycle calls.
 - Provide guidance and technical assistance to states throughout the process.
 - Provide educational resources for Medicaid and CHIP providers.
 - Provide direct communication and support by assigning each state a CMS liaison.
- Review, Resolution, and Recovery of Improper Payments:
 - Review state requested appeals of error findings.
 - Provide states with summary reports to develop corrective actions and the Final Errors for Recovery (FEFR) reports.

General State Responsibilities

- Overall PERM Support:
 - Provide a representative to spearhead PERM who will coordinate state staff and ensure essential staff attend relevant meetings, as well as provide contractors with necessary data and information and keep them apprised of any state issues.
 - Educate state staff and vendors for the Medicaid Management Information System (MMIS) or other data sources on the PERM process and data requirements.
 - Notify CMS and contractors in advance of any program changes, including new or ended programs, new reimbursement methodologies, or new systems.
 - Provide timely and thorough responses to questions on the state submitted data and review issues to support the PERM timeline.
 - Participate in the cycle kick-off meeting, education webinars, all-state, monthly cycle calls with CMS, and bi-weekly check-in meetings with Contractors.
 - Notify contractors of any Data Use Agreements, Business Associate Agreements, or Non-Disclosure Agreements requiring completion.
 - Assist PRC in obtaining systems access.
 - Respond to documentation requests and file Difference Resolutions(DR)/Appeals in a timely manner.

SC Responsibilities

- Collect and Review State FFS and Managed Care Universes:
 - Conduct Intake Meetings with each state.
 - Collect paid, zero dollar paid, and denied FFS and managed care universe data from states on a quarterly basis.
 - Verify data documentation against data submission.
 - Perform quality control review on submissions to ensure universes are accurate, compliant, and complete.
 - Develop and implement sampling unit build (for PERM+).
 - Determine correct sampling units (Header/Fixed/Line) for each type of claim/service.
 - Request clarification or additional submissions, as necessary.
 - Reconcile CMS 64/21 data to confirm all required information is included.
- Select Samples and Format Claims:
 - Select random samples from the universes on a quarterly basis.
 - Request sample details from states for sampled FFS claims for routine PERM states and build details for PERM+ states.
 - Format and verify all mandatory fields needed for PRC review.
 - Deliver samples and details to the PRC.

SC Responsibilities (cont'd)

- Improper Payment Rate Calculation and Reporting:
 - Calculate the component (FFS, managed care, eligibility) improper payment rates at the state, cycle, and national levels for Medicaid and CHIP.
 - Summarize data for corrective action development.
 - Assist in preparing final reports.

State Responsibilities to the SC

- Assign a PERM point of contact:
 - Also, identify a primary data contact, if different than the primary PERM contact.
- Universe Quality Control and Data Submission:
 - Review claims and payment data submission instructions.
 - Provide accurate data documentation (e.g., file layouts, variable field decodes) and claims and payment data to the SC.
 - Conduct a quality control (QC) review of claims, payment, and provider data prior to submission of the quarterly universes to ensure completeness of data and compliance with PERM specifications.
- Participate in meetings with the SC:
 - Data submission instruction meeting.
 - Data intake meeting.
 - CMS 64/21 intake meeting.
 - Details intake meeting.
 - Regularly scheduled and ad hoc calls to respond to data questions.

State Responsibilities to the SC (cont'd)

- Consult subject matter experts (SMEs), as needed to:
 - Participate in calls.
 - Respond to specific data, program, or policy questions.
- Respond timely to questions on universe and details QC.
- Support the CMS 64/21 comparison:
 - Include financial staff familiar with reports.
- Support the SC in developing and approving sample unit build (PERM+) and payment level (Routine PERM).
- Support the SC in developing strata mapping for Fixed, Medicare Crossover, and Aggregate payments.

PRC Responsibilities:

Preparing for DP Reviews & MRs

- Research, collect, and request Medicaid and CHIP state policies, including relevant state and federal regulations, program information, fee schedules, systems, and billing manuals.
- Request from the state any policies that are not publicly available.
- Populate and provide the following documents to the state for review:
 - DP Policy Survey.
 - DP State System Questionnaire.
 - MR/MRR Policy Questionnaire.
 - Review Base Services (RBS) Assessment.
 - Master Policy List (MPL).
- Conduct orientation meetings for DP, MR, and medical record request (MRR) processes.
- Request medical records from providers.
- Coordinate with the states to obtain remote access to systems.
- Host biweekly check in calls with DP/MR/MRR state SMEs.

PRC Responsibilities: Conducting DP Reviews & MRs

- Conduct case collection and DP reviews on all sampled payments.
- Conduct medical/coding reviews on relevant sampled FFS payments.
- Review case actions in accordance with federal and state policies.
- Request additional documentation from the state for DP reviews, as needed.

PRC Responsibilities: Preparing for ERs

- Research, collect, and request state and federal Medicaid and CHIP policies and procedures, including relevant state and federal regulations, program information, fee schedules, systems, and billing manuals.
- Request from the state any policies that are not publicly available.
- Align state eligibility categories with the appropriate federal categories and Federal Medical Assistance Percentage (FMAP) rates.
- Populate and provide the following documents to the state for review:
 - ER Policy Survey.
 - ER Intake Protocol.
 - ER System Access Questionnaire.
 - Eligibility Category Mapping.
 - Eligibility Case Review Planning document.
- Conduct an Intake Meeting with the state.
- Coordinate with the states to obtain remote access to eligibility systems.
- Host biweekly check in calls with eligibility state SMEs.

PRC Responsibilities: Conducting ERs

- Request copies of hard-copy case files, when necessary.
- Gather information from the eligibility and document management systems, including electronic verifications.
- Request additional documentation from the state, as needed.
- Review eligibility case actions in accordance with federal and state policies.

PRC Responsibilities

- Maintain the SMERF system, conduct SMERF training webinars, and provide state access to SMERF to track activities and findings.
- Finalize the Review Findings and Support Improper Payment Rate Calculation and Reporting Process:
 - Report final review findings to the state through Sampling Unit Disposition (SUD) reports on the 15th and 30th of each month or as directed by CMS.
 - Review and respond to requests for difference resolution (DR) and repricing.
 - Process documentation for appeal requests for CMS review.
 - At the end of the cycle, notify states of final overpayment errors for recovery after all DP, MR, and ER reviews are complete.
 - Compile and submit final findings to the SC.
 - Assist in preparing final reports.

State Responsibilities to the PRC

- Assign a state ER, DP, and MR/MRR point of contact.
- Educate providers on the PERM process and assist with medical record collection.
- Have appropriate state staff thoroughly complete and return questionnaires in a timely manner.
- Assist the PRC with accessing state policies for review.
- Work with the PRC to grant remote system access timely to prevent review delays.
- Assist the PRC and answer questions related to ER, DP, and MR reviews within the prescribed timeframes.
- Monitor PERM IDs on the pending documentation lists in SMERF (EP1, P1) and provide missing documentation timely.

State Responsibilities to the PRC (cont'd)

- Participate in meetings with the PRC and CMS, including:
 - Eligibility Case Review Intake Meeting.
 - SMERF system training.
 - DP orientation.
 - MR/MRR orientation.
 - System access meetings, as needed.
 - Biweekly check-in meetings and other ad hoc meetings (throughout the case review process).
- Review, Resolve, and Address Improper Payment Findings:
 - Track errors, request DRs/appeals for disputes of findings, and re-price partial errors.
 - Submit requests for DR and appeal within the prescribed timeframes, if needed.



Differences Between RY 2025 and RY 2028 Cycles

SC Processes: New to Cycle 1

- New field required in either the PERM+ or routine PERM universe submission:
 - Capitation Reason Code
 - This field contains information about the type of capitation payment made (e.g., PN – Payment Normal, PR – Payment Retro, RA – Rate Adjustment).
 - Federal Medical Assistance Percentage (FMAP) (optional but noting for awareness)
 - FMAP (or Enhanced FMAP) applicable to the specific payment based on member eligibility, date, and service category. Please note this field is optional.

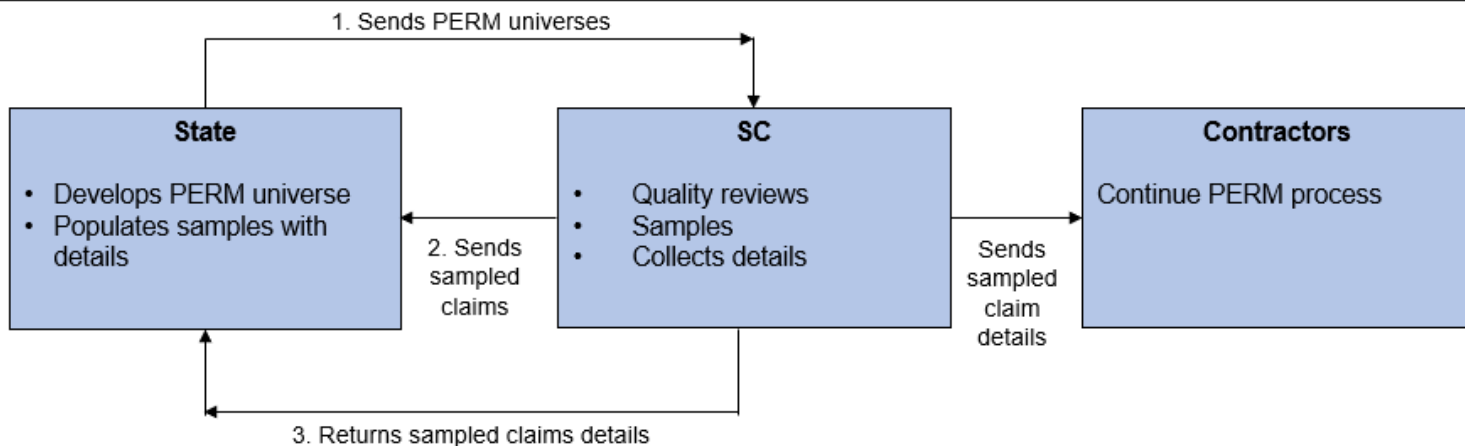
PRC Processes: Cycle 1 Reminders

- Ongoing Documentation Submission:
 - The PRC will accept missing or insufficient documentation for ER1, ER2, ER3s as well as MR1 and MR2 errors until the end of the cycle for cases with missing and insufficient documentation errors.
 - States will continue to have 30 calendar days to submit documentation for EP1.
 - States will continue to have 14 calendar days to submit documentation for DP P1.
 - If the state has not responded within the allotted timeframe for each review type, the PRC will move forward with completing our case review.
 - Documentation to address ER1, ER2, and ER3 errors will be accepted until cycle cut-off.
- Independent Verification
 - The PRC will accept additional information and verifications to independently verify the eligibility of the beneficiary. The PRC will look for any information that supports beneficiary eligibility despite the state not maintaining documentation of verification.
 - The PRC DP team will independently verify risk-based screening database checks for providers where the state either did not perform a database check or did not document the results of the check.
- Error Codes and Qualifiers:
 - The PRC will use updated error codes and qualifiers for the review findings.
 - The PRC expects only minor changes from the RY 2025 error codes and qualifiers.

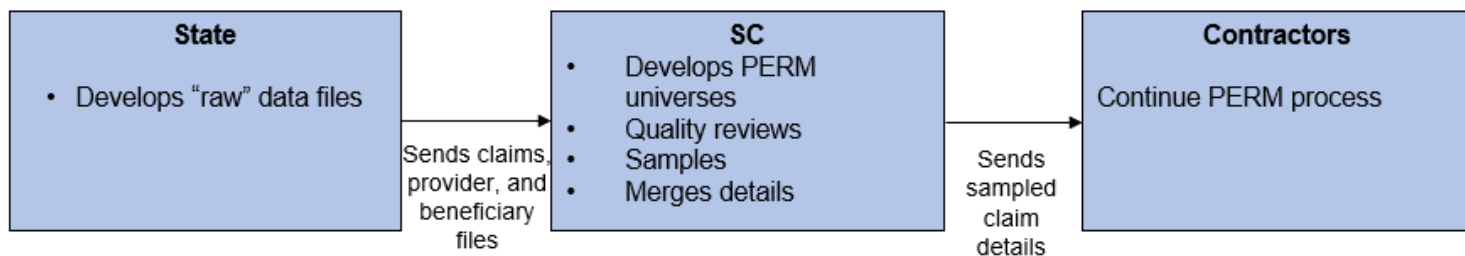


SC Process Details

Routine PERM



PERM Plus



SC: Universe Collection

- PERM independently samples payments from four universes or program areas:
 - Medicaid FFS.
 - CHIP FFS.
 - Medicaid managed care.
 - CHIP managed care.
- The PERM universe contains Medicaid and CHIP service payments that are fully adjudicated by the state that are matched by federal funds each quarter except those which are excluded.
 - Includes individual claims, capitation payments, and payments processed outside of MMIS or made in aggregate for multiple services.
 - Includes expansion program data.
 - Excludes claim adjustments, administrative payments, state-only expenditures, and certain payments as defined in regulation.
- Certain fields (e.g., date paid, amount paid) have PERM-specific definitions that are important for consistency.

SC: Sampling

- Both FFS and managed care universes are stratified prior to sampling.
- RY 2028 will use the following stratification approach:
 - FFS is stratified into 5 dollar-weighted strata (including \$0 paid) with one additional strata for claims that are only capable of receiving DP review (e.g., fixed payments, Medicare premiums, and Medicare crossovers).
 - Managed care is stratified into 5 dollar-weighted strata.
- The SC will calculate state-specific sample sizes for each claim component in each state.
- Final sample sizes will be sent on June 1st.

SC: Improper Payment Rate Calculation

- For each state, improper payment rates are estimated separately for Medicaid and CHIP:
 - Improper payment rates are estimated using a sample of claims.
- FFS, managed care, and eligibility rates are calculated separately (where applicable).
- The FFS and managed care rates are combined to make the claims rate based on the state expenditures of each program.
- The claims rate is then combined with the eligibility rate.



PRC Process Details

PRC: Collection of State Policies

- ER/DP/MR/MRR Policy collection process:
- Send initial email to state prior to implementation:
 - Explain policy collection process and timeframes.
 - Establish policy contacts with each state.
- Collect policies from state websites (as many as publicly available)
- Submit to state for review and approval:
 - ER and DP Policy Survey
 - MR/MRR State Policy Questionnaire
 - Master Policy Lists (MPL)
- Upload policies into SMERF system.
- Check for policy updates throughout the cycle.

PRC: Remote State System Access

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

State Medicaid Error Rate Findings (SMERF)

- SMERF is the single system for the state to view DP, MR, and ER findings. SMERF also:
 - Tracks all sampled unit workload, reviews pending information, reviews completed, and final results for all review types.
 - Provides real-time information on status of record requests and receipts and progress of DP, MR, and ER reviews.
- States use the SMERF system to:
 - View ER, DP, and MR findings through the SUD reports published on the 15th and 30th of each month.
 - Create and/or download reports, file for DR and CMS appeals.
 - Access educational resources.
 - Add contact information to receive PERM alerts (automated email notifications).
- Training and access to the SMERF system is provided before records are requested or reviews are started.



Overview of Review Types

DP Reviews

- DP reviews are conducted on each sampled FFS claim, fixed payment, and managed care payment.
- The PRC validates that the claim was processed correctly based on information found in the state's claims processing system and provider files.
- DP webinars are scheduled with each state prior to reviews.
 - Review state system(s) questionnaire completed by states.
 - Review any special programs (waivers, etc.).
 - Determine and gather desk aids, manuals, and website links needed for training DP reviewers.
 - Review Risk-Based Screening (RBS) Assessment.
 - Establish tentative dates to begin reviews.
- The state tracks pending DP reviews through SMERF and receives automated notices for overdue pending information needed to complete

Reminder: States are allowed to submit missing documentation for DP1, DP2, and DP3 errors throughout the cycle until cycle cut-off.

DP Reviews:

Beneficiary Review

- Reviewer reviews and verifies the following:
 - Beneficiary ID.
 - Date of Death.
 - Date of Birth/Age.
 - County of Residence.
 - Gender.
 - Citizenship Status.
 - Living Arrangements.
 - City/Zip code (if needed to determine managed care status).
 - Aid category/program eligibility and effective dates, (relative to sampled dates of service).
 - Managed care/health plan enrollment.
 - Patient Liability/level of care, if applicable.
 - Medicare and/or other insurance coverage (TPL).

DP Reviews:

Verification of Provider Enrollment

- Only reviewed when provider is required to be enrolled.
- The DP team reviews and verifies the following:
 - Provider Name.
 - Provider National Provider Identifier (NPI) Number.
 - Registration/enrollment.
 - Provider License (if required).
 - Clinical Laboratory Improvement Amendment (CLIA) Certification (if required).
 - Type/specialty.
 - Provider and Service Location.
 - Provider Sanctions/Suspension Periods.
 - Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) verification check conducted independently.
 - Compliance with provider enrollment/RBS requirements under the Affordable Care Act (ACA).
 - Provider revalidation.
 - RBS Independent Verification

DP Reviews:

Verification of Accurate Payment

- Reviewers determine the following:
 - The payment was for a covered service.
 - The payment was accurately calculated.
 - To ensure these two requirements are met and complete, reviewers will:
 - Verify timely filing requirements.
 - Review reference screens with service parameters*.
 - Review reference screens with rates†.
 - Verify service coverage determination.
 - Review prior authorization requirements.
 - Verify prior authorizations issued‡.
 - The payment went to a properly enrolled/screened provider.
 - The payment went to a beneficiary that was eligible to receive services under the funding source that paid.

* *National Drug Code (NDC), procedure codes, revenue code, etc.*

† *Diagnosis Related Group (DRG), NDC, per diem, provider contract, procedure codes, revenue codes, Relative Value Unit (RVU), etc.*

‡ *Service codes, effective dates, units, rates, etc.*

DP Reviews:

Verification of Accurate Payment (cont'd)

- Reviewers will independently price each sampled payment manually to determine if the payment was made in accordance with published state policies and rates in effect for the dates of service under review.
- Reviewers will need access to the rates that were in effect for the dates of service for claims under review, including those housed outside of MMIS.
- Reviewers will also need:
 - Information about how the state calculates each type of payment.
 - The ability to complete a duplicate check to ensure the same service was not paid more than once or to multiple providers for the same dates of service.
 - Hard copy paper claims or the ability to view the scanned image of the paper claim to verify accurate transference of information to the payment system.
 - To view any adjustments made within 60 days of the original sampled claim payment date.
 - Access to value code tables or a data dictionary of codes used in the system if not contained in system help.

DP Reviews:

Managed Care Capitation Payment

- Reviewers will review all beneficiary information listed under FFS review.
- Reviewers will also need access to:
 - Capitation rates.
 - Capitation payment history screens.
 - Geographical service areas (counties, zip code).
 - Managed care contract for sampled claims.
 - Population carve-outs.
 - Service carve-outs.
 - Rate cells.

MR/MRR Reviews

- The PRC holds MR/MRR orientations with the states to review the MRR processes before starting calls to providers.
- The PRC uses the provider and MR point of contact information received in the details files submitted by the states to contact providers and send request letters.
- Provider information is verified during the initial live call. If the provider cannot be reached, state support is needed to help identify the correct contact information.
- Initial letter request packets sent to providers include:
 - CMS letter (with authority to request records).
 - PERM fax cover sheet with specific list of requested documentation (unique to each claim category).
 - Claim summary data provided for specific claim sampled.
 - Instructions with different options for record submission.

MR/MRR Reviews: Provider Information

- Providers have 75 calendar days to send in medical records:
 - The PRC will follow up with reminder calls and reminder letters.
 - A 75-day non-response letter is sent to providers via certified mail if no MR documentation has been received. An *MR1: No Reviewable Documentation Received* error is cited if no records are received.
 - If documentation is submitted and is missing information, the PRC sends an additional documentation request (ADR) letter to the provider.
- Providers have 14 calendar days to send in documentation in response to an ADR:
 - If no ADR response is received, a 15-day non-response letter is sent. An *MR2: Document(s) Absent from the Record* error is cited if documents are missing from the record.
 - If an ADR response is received but does not include all the requested items, an Incomplete Information letter is sent to the provider specifying the missing item(s) and an MR2 error is cited.
- States receive copies of all letters to providers on a weekly basis via the PRC's Secure File Transfer Protocol (SFTP).
- Late documentation for MR1/MR2 errors can be accepted until the cycle cut-off date.

MR/MRR Reviews

- Conducted only on sampled FFS claims.
- Utilizes claims data submitted by state, records submitted by providers, and collected state policies.
- Validates whether the claim was paid correctly by assessing the following:
 - Adherence to federal and state guidelines and policies related to the service type.
 - Completeness of medical record documentation to substantiate the claim.
 - Medical necessity of the service provided.
 - Validation that the service was provided as ordered and billed.
 - Claim was correctly coded.

ERs

- Determine case action(s) and action date(s) for review; the review will include:
 - The most recent determination or redetermination prior to the date of service; and
 - Any changes in circumstance that required an action if it occurred prior to the date of service of the sample claim.
- Access and review information used by the state to process the case in the form of system screenshots and case documents that support the eligibility determination.
- Review eligibility elements against federal and state policies in place at the time of the action under review and determine if the case is correct or if a payment error should be cited.

ERs:

Eligibility Case Review Planning Document

- The purpose is to have a shared document among the state, the PRC, and CMS that outlines necessary components of the cycle activities and provides details necessary for conducting eligibility case reviews.
- The Planning Document includes information such as:
 - State, CMS, and Eligibility points of contact.
 - State characteristics.
 - State eligibility systems summary.
 - State eligibility verification requirements.
 - Active waiver and mitigation plans for eligibility.
 - State eligibility categories and FMAP rates.
 - Paper case file collection process.
 - PERM tasks and timeline.
 - DR and appeals process.
 - Eligibility category mapping.
 - System access questionnaire.
 - MAGI verification plan.
 - Any additional state-specific information.

ERs:

Pending Documentation Requests

- Upon the PRC's initial review of the information collected, we may identify cases with missing information or incorrect timeframes in which the PRC will request the state to provide the documentation.
 - The PRC will also answer any questions about the documentation request during the regularly scheduled bi-weekly check-in calls.
- States will be notified of a pending documentation request via the SMERF system as an EP1.
- States will submit the requested documentation to the PRC via its SFTP within the requested timeframe.

Reminder: States are allowed to submit missing documentation for ER1, ER2, and ER3 errors throughout the cycle until cycle cut-off.

ERs:

FMAP Collection

- The FMAP rate will be collected by the PRC to identify federal dollars assigned to a claim for each type of PERM review based on the eligibility category and the date the claim was paid.
- States will have the opportunity to review and validate the FMAP assigned to claims when review findings are posted to SMERF. States can request changes to the FMAP rate for specific claims to ensure payments are calculated as accurately as possible.



Best Practices

Best Practices for State: Working with the SC

- Assign a dedicated contact person for all communications.
- Include relevant staff in all PERM meetings:
 - For general intake meetings, it is important that all departments that will be pulling data or responding to questions about PERM data be in attendance.
 - If vendors will be pulling and/or submitting PERM data, they should be included in intake meetings and calls with the SC.
 - All relevant financial staff should be included in the CMS 64/21 intake meetings.
 - The universe build and payment level meeting should include all relevant staff.
- Check FTP compatibility before submitting the Q1 data:
 - This includes encrypting, password-protecting, and uploading file.
- Submit test data to ensure that the submission can be read and reviewed by the SC:
 - State should perform quality checks to make sure data fields are uniformly populated with valid values.
 - State should compare data documentation submitted with data – file layouts and variable decodes – are all up to date and accurate for timeframe of data supplied.
 - Note any additional variables included in the data submission to assist state staff or the SC in identifying correct claims.

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

- Keep a list of all data sources and ensure that data from all sources are included in the state transmission each quarter:
 - Identify the relevant staff who are involved in the data analysis portion of the project and involve them from the start of the cycle.
- Include subject matter experts as part of the PERM team early in the cycle to gain clear understanding of data submission instructions and PERM requirements.
- Refer to information from the previous cycle, as appropriate, to resolve issues and answer questions.
- Participate in regular meetings with the SC to resolve data issues if there are significant complications or delays.
- Perform a round of CMS-64/21 reconciliation early in the cycle to ensure that corrections in data submission can be made for the remaining quarters.
- When submitting anything to the SC via the SFTP, please email the PERMSC.2028@lewin.com inbox to alert the SC of this submission as well as provide a password to open the documents if needed.

Best Practices for State: Working with the SC (cont'd 2)

- For PERM+ states, work with the SC to identify the most efficient method of submitting data, which may include submitting some data through a routine PERM method.
- For PERM+ states, verify that beneficiary and provider information given to SC in separate files are able to be correctly merged onto the claims file.
- Establish a stream of communication or dialogue from the beginning of the cycle with your SC contact.
- Ask questions proactively.
- Have helpful information related to PERM readily available to share with your staff:
 - SC contact list.
 - Data submission instructions.
 - Details submission instructions.

Best Practices for State: Working with the PRC

- Allocate resources to PERM throughout the cycle at each phase of the project.
- Correct any issues identified from the last PERM measurement cycle.
- Collaborate with the PRC to explain the state programs, data, and policies.
- State subject matter experts from the appropriate state departments attend and participate in check-in calls.
- Establish system access for the PRC early:
 - Identify all systems required by the PRC.
 - Provide all required system access forms as soon as possible.
 - Designate an individual to work with PRC on system access.
 - Identify all security/privacy training reviewers will need to complete.
- Provide systems training to eligibility and DP reviewers.
- Monitor the ER and DP P1 list and provide documentation in response to the pending documentation requests timely.

Best Practices for State: Working with the PRC (cont'd)

- If the state routinely purges claims:
 - Have the purge process held until after PERM reviews.
 - If already purged prior to sampling, identify all purged sampled claims and have the full claim re-populated in the system prior to the start of DP reviews.
 - Keep provider licensing information updated in the MMIS system.
 - Update provider contacts in MMIS for claims sampled for PERM before the state submits quarterly detail data to the SC. If the state later discovers a change in the provider contacts after submitting detail data to the SC, provide the PRC with updated provider contact information.
 - Send outreach letters to each sampled provider about the PERM program and MRR processes before medical record requests begin.
 - Identify a contact person for corporate medical organizations, school systems, and state fiscal agencies.

Best Practices for State: Working with the PRC (cont'd 2)

- Engage a cross-functional state PERM eligibility team that includes policy, systems, claims, program integrity, IT, and operations:
 - Ensure appropriate team members attend biweekly check-in calls.
- Support the collection of Medicaid and CHIP policies:
 - Identify policies not publicly available and submit to the PRC.
 - Review ER and DP Policy Survey promptly and provide feedback.
 - Notify the PRC of any changes throughout the cycle.
- Respond to the request to review the Intake Protocol, System Access Questionnaires, Eligibility Category Mapping, Eligibility Planning Document, RBS Assessment, MR/MRR Policy Questionnaire.
- Review, ask, and respond to questions involving the case review process.

Best Practices for State: Working with the PRC (cont'd 3)

- Develop teams to assist with locating and contacting providers, when needed.
- Track all MRRs in SMERF to assure providers' timely responses.
- Contact providers on all non-response errors (MR1s for no documentation and MR2s for document(s) absent from record) to submit requested documentation.
- Encourage providers to contact the PRC with questions about the MRR letters at PRC_RY2028@bah.com. *Remind them not to send records, PHI, and PII to this email address.
- Use the Advance Error Notice notification from SMERF to review all errors cited and determine if a DR request should be filed within 25 business days of the SUD report.
- Utilize the DR process to formally request repricing or, if that timeframe has expired, submit a request for repricing to the PRC via email and submit appropriate documentation before cycle cut-off.
- Review all DR decisions where errors were upheld and determine if an appeal should be filed within 15 business days of the SUD report.

SFTP Reminder

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



Communication, Resources, and Contact Information

Communication and Resources

- **RY 2028 PERM Cycle 1 Calls:**
 - The cycle calls will occur on the fourth Wednesday of each month from 2-3:00pm Eastern Time.
 - First cycle call will be held in June or July.
 - In lieu of a cycle call written updates will be provided.
- **Regular State Check-in calls:**
 - Will be scheduled with each state by contractors.
- **CMS PERM Website:**
 - [CMS PERM - Cycle 1](#).
 - [PERM Manual](#).
 - The PERM RY 2028 Cycle 1 Kick-off Presentation will be available soon on the CMS PERM - Cycle 1 website.
- **PERM Corrective Action Plans - CMS Division of State Partnership:**
 - PERMCAPS@cms.hhs.gov

PERM State Liaison Contact Information

Cycle 1 States	CMS PERM State Liaison
Arkansas, Missouri	Jailynne Price (Jailynne.Price@cms.hhs.gov)
Connecticut, Illinois	Misha Patel (Misha.Patel@cms.hhs.gov)
Delaware	Caitlyn Brown (Caitlyn.Brown@cms.hhs.gov)
Idaho, Minnesota	Ray Antoine (Ray.Antoine@cms.hhs.gov)
Kansas	Aileen Almario (Aileen.Almario@cms.hhs.gov)
Michigan, Virginia	Elise Hanks-Witaszek (Elise.HanksWitaszek@cms.hhs.gov)
North Dakota	Gwynne Warren (gwynne.warren@cms.hhs.gov)
Wisconsin	Alan Mahmulin (alan.mahmuljin@cms.hhs.gov)
New Mexico, Wyoming	Angela Jones (Angela.Jones3@cms.hhs.gov)
Ohio	Daniel Weimer (Daniel.Weimer@cms.hhs.gov)
Oklahoma	Daniel Hendricks (Daniel.Hendricks@cms.hhs.gov)
Pennsylvania	Anita Moore (Anita.Moore@cms.hhs.gov)

SC Contact Information

The Lewin Group

PERM Statistical Contractor

3237 Airport Rd.

LaCrosse, WI 54603

Phone: 703-269-5500

All PERM correspondence should be directed to our
central PERM inbox:

PERMSC.2028@lewin.com

PRC Contact Information

Booz Allen Hamilton

PERM Review Contractor
8283 Greensboro Drive
Hamilton Building
McLean, VA 22102

All PERM correspondence should be directed to our
central PERM inbox:

PRC_RY2028@bah.com