Payment Error Rate Measurement (PERM) Manual

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I. Payment Error Rate Measurement Program Introduction

A. Overview of the Payment Error Rate Measurement Program

The purpose of the Payment Error Rate Measurement (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 the Improper Payments Elimination and Recovery Improvement Act (IPERIA) (2012). The Centers for Medicare & Medicaid Services (CMS) uses a 17-state rotation per cycle, reviewing each state every three years. The PERM Statistical Contractor (SC) selects a stratified random sample of payments from each state's universe of payments for one Reporting Year (RY). The PERM Review Contractor (RC) reviews all claims sampled to determine if each state's payment decisions complied with applicable federal regulations and state policies. The PERM Eligibility Review Contractor (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

The Improper Payments Information Act of 2002 (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 the Office of Management and Budget (OMB) to provide guidance on implementation. OMB defined "significant erroneous payments" as annual erroneous payments in the program exceeding both 2.5 percent 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 the Department of Health and Human Services (HHS) to report the estimated improper payment rates for the Medicaid program and CHIP each year for inclusion in the Agency Financial Report (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 percent confidence. An "adjudicated claim" is a claim for which either the payer obligated money to pay the claim (paid claims) or for which the payer made a decision to deny the claim (denied claims).

The Improper Payments Elimination and Recovery Act (IPERA), Pub. L. 111-204, amended the IPIA on July 10, 2010. IPERA requires agencies to conduct annual risk assessments, and if an

agency finds a program to be susceptible to significant improper payments, the agency must measure improper payments in that program.

On January 10, 2013, IPERIA, Pub. L. 112-248, further amended IPERA. The aim of IPERIA is 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, the Payment Integrity Information Act of 2019 was signed into law, which revoked IPIA, IPERA, and IPERIA and incorporated key elements to maintain an improper payment measurement.

C. CMS RULEMAKING

Section 1102(a) of the Social Security Act (the Act) authorizes the Secretary to establish rules and regulations necessary for the efficient administration 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 42 Code of Federal Regulations (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 Fee-For-Service (FFS), Managed Care (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' 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 cycle 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 the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3). Sections 203 and 601 of the CHIPRA relate to the PERM and Medicaid Eligibility Quality Control (MEQC) programs. Section 203 of the CHIPRA establishes an improper payment rate measurement with respect to the enrollment of children under the Express Lane Eligibility (ELE) option. The law directs 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 the CHIPRA provides for a 90 percent federal match for CHIP expenditures related to PERM administration and excludes 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 percent of the CHIP benefit expenditures for outreach efforts, additional services other than the standard benefit package for low-income children, and administrative costs.) The 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. The CHIPRA required that the new PERM rule include:

- 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 Corrective Action Plans (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, the 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 the 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 48815). In addition to the provisions required by CHIPRA, the final PERM rule (75 FR 48815) addresses the claims universe, sampling, and review; the eligibility universe, sampling, and review; error determination and rate calculation; Difference Resolution (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 Data Processing (DP) review process expanded to ensure state compliance with new provider enrollment and risk-based screening requirements. The RC reviews provider information to verify billing, ordering/referring, and some attending/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.[1]

On July 5, 2017, CMS published a final rule in the Federal Register (82 FR 31158) that implements changes to the PERM program and implements 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.

[1] Guidance related to the pilots can be found on the CMS PERM website CMS PERM Pilots Guidance.

Specific changes to the PERM program in this final rule include changing the review period so that PERM reviews state Medicaid and CHIP payments July through June of a given year (instead of the October through September federal FY). The ERC conducts PERM eligibility reviews on beneficiaries associated with sampled FFS and MC claims, with support from each state.

The PERM program cites improper payments if the federal share amount is incorrect (even if the total computable amount is correct). Previously, PERM only cited improper payments on the total computable amount (i.e., federal share plus state share). The PERM program calculates a national sample size to meet national Medicaid and CHIP improper payment rate precision requirements. PERM distributes the national sample size across states to maximize precision at the state level. The basis for state-specific sample sizes includes factors such as a state's expenditures and previous improper payment rate. Previously, PERM calculated state-specific sample sizes based on the state's previous improper payment rate and state-level precision, combining this information to generate the national sample size. Under the new rule, states continue to implement CAPs for all errors and deficiencies; however, there will be more stringent requirements added for states that have consecutive PERM eligibility improper payment rates over the 3 percent national standard.

The final rule also makes changes to the MEQC program—a separate eligibility review program that requires states to report to the HHS Secretary the ratio of states' erroneous excess payments for medical assistance under the state plan to total expenditures for medical assistance. These changes include: the restructuring of the MEQC program into a pilot program that states must conduct during their off-years from the PERM program; a requirement for states to review a number of items not fully reviewed through the PERM program (e.g., negative cases); a mechanism that enables CMS to provide direction for reviews if states have consecutive PERM eligibility improper payment rates over the 3 percent national standard; and a requirement for states to submit corrective actions for identified errors.

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.

a. Statistical Contractor

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 for the state to build the FFS and MC universes 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
- 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 Third-Party Liability (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 or 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, the SC will send the samples to the RC, ERC, and states for preparation.

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.

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.

b. Review Contractor

The RC has three primary responsibilities: collection of federal regulations and state policies, obtaining medical records for sampled payments, and conducting DP review and Medical Review (MR).

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 risk-based screening
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 electronic claims standards
- Appropriate level of care and documentation standards

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

- 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, 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 schedules DP reviews with each of the states. 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.

c. Eligibility Review Contractor

The ERC has two primary responsibilities: collection of 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 Date of Service (DOS) is the action under review.

d. State Partners

States are critical partners in the PERM process and have the following responsibilities, including:

- Identifying and supporting a state representative who serves as the central point of contact 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 quality control reviews prior to submission to ensure compliance with specifications
- 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 MR

e. 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 measurement 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

E. PERM CYCLES

CMS review periods for PERM run from July to June and are in line with each states' RY.

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 50 states and the District of Columbia 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 group of 17 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

Cycle	States
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, South Dakota, Texas, Washington

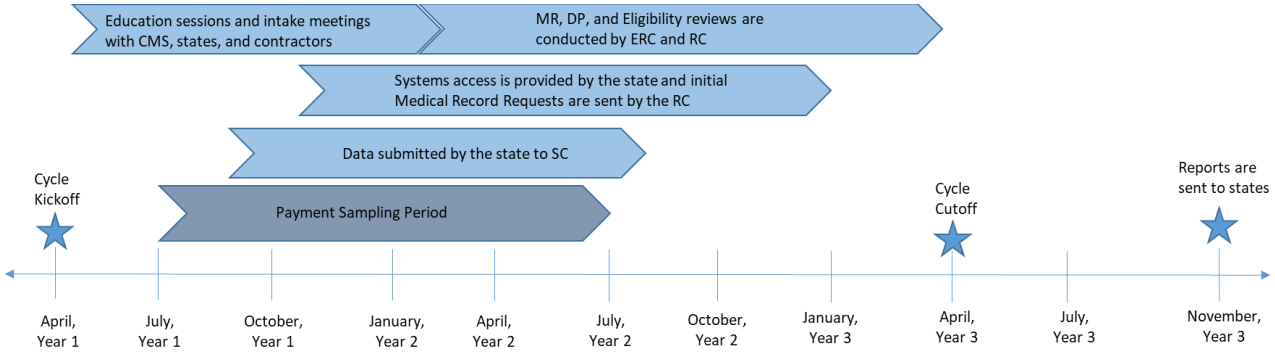
CMS assigns a PERM State Liaison from the agency to each state within each PERM cycle. The PERM State Liaison serves as the state's main point-of-contact for that measurement, ensures the measurement timeline stays on track, and handles any issues that occur throughout a cycle.

a. 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 II – PERM Sampling Universe.

Exhibit 2. PERM Process Estimated Timeline



b. Data Use Agreement

The RC, ERC, and SC require access to sampling units stored in states' Medicaid Management Information Systems (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, in the Federal Register (42 CFR Parts 431 and 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 provisions requiring security measures and imposing limitation on use.

c. 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; Medicare Secondary Payer (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.

Records that support compliance and integrity activities and functions including: plans, agreements; administrative records, records related to surveys, reviews, and audits; reports; and legal records related to compliance and integrity operations. Temporary, destroy when **7 years old** or when no longer needed for agency business, whichever is later.[2]

[2] Disposition Authority: DAA-0440-2015-0012 - Compliance and Integrity

II. 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; state and national-level improper payments are extrapolated by the SC 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 IPERIA statutory requirements, OMB guidance, and the PERM regulation. 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

a. Payment Amount

IPERIA 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, 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 Federal Medical Assistance Percentage (FMAP)

[3] Improper Payments Elimination and Recovery Improvement Act of 2012

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. In Section 3, we describe the PERM sampling methodology, which underscores the importance of the correct total computable amount in the PERM universe.

b. 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 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
RY20 – Cycle 2	July 1, 2018	June 30, 2019
RY21 – Cycle 3	July 1, 2019	June 30, 2020
RY22 – Cycle 1	July 1, 2020	June 30, 2021
RY23 – Cycle 2	July 1, 2021	June 30, 2022

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 2.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, 2018 to June 30, 2019 cycle makes a retrospective capitation payment on July 5, 2018, for coverage in June 2018, 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, 2018 for coverage in July 2018, 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.

c. 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 Federal Financial Participation (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.

d. 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 for these payments.

e. 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. Fee-For-Service and Managed Care 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., Managed Care Organization [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.

a. Fee-For-Service 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/Durable Medical Equipment (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 Prepaid Inpatient Health Plans/Prepaid Ambulatory Health Plans (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.

b. 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., Program of All-inclusive Care for the Elderly [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 IPIA 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.

c. Small FFS or Managed Care 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. For instance, 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 precedence guides combining the very small component and the large single universe, where the former 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, PACE, is less than two percent of the total Medicaid expenditure, then PACE would be included in the Medicaid FFS universe. Similarly, if the state's only FFS program for CHIP beneficiaries accounts for less than two percent of the total CHIP expenditures, then this vaccination program would be included in the CHIP MC 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.

d. 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 Primary Care Case Management (PCCM), disease management, and Non-Emergency Medical Transportation (NEMT). Additionally, payments made to individuals or health plans through Health Insurance Premium Payment (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."

e. 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

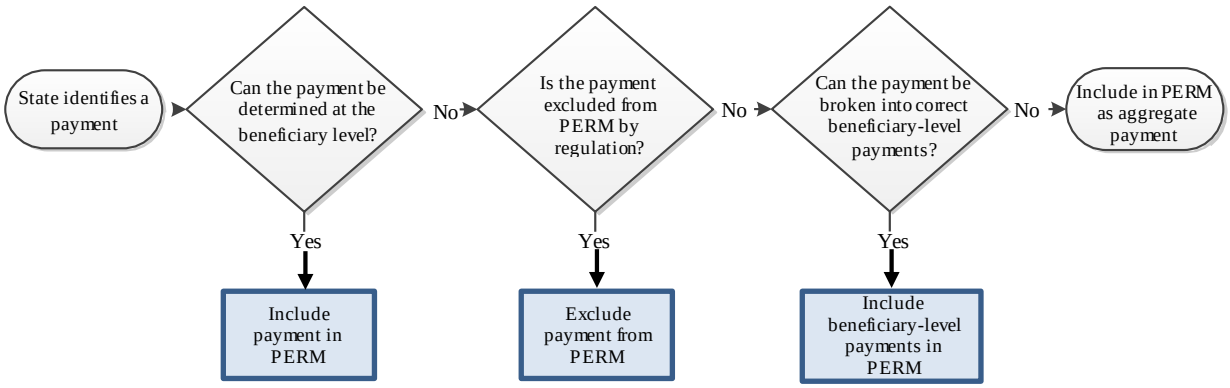
to these as "aggregate payments." Unless otherwise specified by CMS, aggregate payments for services are subject to sampling and review in PERM. These payments are included in the PERM universe regardless of whether the state claims FFP at the medical services match rate or as an allowable administrative 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 4. 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.

f. 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. Further excluded from the PERM universes are encounter records for capitation or other encounter-based payments. 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. In this section, these PERM exclusions are described in detail.

a. Adjustments

Since each payment is included in the PERM universe once and only once, the routine PERM universe may not have the original payment and 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 them. 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, 2018, PERM will consider any adjustments made prior to November 13, 2018.

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 State Plan Amendments (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), Federally Qualified Health Centers (FQHCs), and Rural Health Centers (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.

b. 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.

c. 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.

d. 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.

e. 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 the 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.

f. 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 Indian Health Services (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, documentation, recommended quality checks by the states prior to submission, due dates, and data security are discussed.

a. 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.

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 to create clean universes from which samples can be selected. The second data submission contains detail information for the sampled FFS payments. These sample details are required for DP review and MRRs.

Please refer to the CMS PERM website[4] 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 CMS PERM website[3] for the PERM+ Data Submission Instructions.

b. 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

[4] PERM Web site

- 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

c. 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

Note: These days are subject to change if they fall on a non-business day.

d. 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 on the CMS PERM website[5] for instructions and guidance on data quality review and on comparing PERM data to CMS Financial Management Reports.

e. Data Security

Under PERM, states submit data that contain Protected Health Information (PHI), including electronic Protected Health Information (ePHI) and Personally Identifiable Information (PII). 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

[5] PERM Web site

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 (FIPS) 140-2 and validated by the National Institute of Standards and Technology (NIST) module.[6]

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.[7]

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.

[6] FIPS 140-2 and NIST module

[7] 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.

III. 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, then extrapolates from the review findings for the samples to estimate the improper payment rate for the program universes.

PERM is designed to fulfill the requirements of IPERIA 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 the following; PERM sampling units, sampling process (including sample size determination), stratification, and improper payment rate estimation.

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.

a. 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 Diagnosis-Related Group [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 are 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.

b. 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 (co-payment 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, and 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 together 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

IPERIA requires an estimated national improper payment rate bound by a 95 percent confidence interval of 3 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 percent confident that the improper payment rate for the sample is within plus or minus 3 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 national sample size will first be determined for the year. The national sample size will be distributed among the 17 cycle states depending on individual state precision needs, improper payment rates, and expenditures. After the allocation of the national sample across states has been performed, every state will have a FFS, MC, and eligibility sample (unless a state does not have a MC program and, therefore, only has a FFS and eligibility sample, for example). The claims (FFS and MC) and eligibility samples will be 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, then 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 for FFS. 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 for the MC universe for the MC and eligibility MC samples.

a. Sample Size for Claims and Capitation Payments

Section 601(f) of the 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 IPERIA.

In addition, CMS established a maximum sample size for each state of 20 percent of the total sample size for the claims across all 17 states in a cycle. Since reviewing claims requires both staff and monetary resources and a cycle sample size will be divided amongst the 17 states, a maximum sample size puts a limit on expenditures and the number of claims to be sampled per state. 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 percent 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 3 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. States confidence intervals are based on a 95 percent confidence interval.

b. Fee-For-Service 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 percent of the dollars in the universe. Payments are sorted and applied to each stratum, so that a small number of high-dollar payments are placed in the first stratum and a large number of very small payments are placed in the last stratum.

In addition to the five payment-based strata, there is an additional stratum consisting of fixed payments, aggregate payments, Medicare premium payments, Medicare crossover claims, and denied 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 percent of the total state sample). Below, an example of dollar-weighted stratification is summarized.

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 percent 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 percent 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 lines (the lines in the first stratum are the highest-dollar lines, so it takes fewer of them to add up to 20 percent of expenditures), while the last stratum will have a very large number of lines. 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 on 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

c. 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.

d. 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.

e. Modifications to the Sampling Process

The previous section provides the sampling procedure when the universe information is accurate. In practice, problems with the universe data are often discovered after a sample has been selected and review is under way. Although, ideally, that sample should be dropped from review and a new sample should be selected from the corrected universe, in the interest of time and burden to the RC, ERC, and state, selecting a replacement sample may not be feasible. In such situations, the following steps are taken to correct the sample.

Step 1: A correct universe is created using updated data provided by the state.

Step 2: Sample sizes needed for each stratum are recalculated from the corrected universe.

Step 3: All lines in the original sample that exist in the corrected universe are retained in the corrected sample, if it is possible to do so while preserving a valid sample.

Step 4: Before sampling, all claims from the original sample are withdrawn from the corrected universe and accurate sampling frequencies are calculated.

Step 5: Additional sampling, to eliminate any difference between the new required sample size for each stratum and the valid portion of the original sample, is taken from the corrected universe.

Step 6: The sampling procedure described in the previous section is applied to the additional sampling from the corrected universe.

Following these steps ensures the randomness of the sample within each stratum and that accurate sampling frequencies can be calculated so that the population inferences remain unbiased. There might be cases where this process results in more than the required number of lines in a stratum due to the reallocation of the sample prescribed by the corrected universe file.

f. 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.

g. 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. Claims that were denied due to reasons unrelated to eligibility are included in the eligibility sample. And claims that were denied by the state and beneficiary information is available are also included in the eligibility sample.

- ELE cases where the state relied on a separate program determination on the beneficiary.

IV. 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. Policy Collection by Review Contractor

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 State Medicaid Error Rate Findings (SMERF) system for claims under review during the PERM review cycle. Policies used in the PERM review may include:

- Rules/regulations
- Manuals/handbooks
- Bulletins/updates/notices
- Clarifications/reminders
- Fee schedules/codes
- SPAs [as relevant and approved by the Center for Medicaid & CHIP Services]

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 Master Policy List (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. 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.

B. Policy Collection by Eligibility Review Contractor

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 the 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

- State Modified Adjusted Gross Income (MAGI) policy
- State non-MAGI policy
- State CHIP policy
- Medicaid bulletins
- Waivers

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.

V. Medical Record Request 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. The states can use SMERF to track MRRs and a user guide is available on the SMERF homepage, should the state require assistance.

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 Medical Record Request[8]

If the provider prefers to receive record requests via fax, the RC will fax its Initial Request for 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 point-of-contact at the confirmed address via standard United States Postal Service (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' 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 parts 160 and 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.

[8] See example of a Medical Record Request in Appendix C.

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, Tenth Revision, Clinical Modification (ICD-10-CM)]
- Service code [Current Procedural Terminology, Healthcare Common Procedure Coding System, 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, etc.) 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, CD, or electronic submission of Medical Documentation (esMD). For more information about esMD, see www.cms.gov/esMD.

C. Follow-up Medical Record Requests

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 and the RC will contact the provider by phone and send a letter to request the 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 count 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 sends a final letter that contains the detailed information request. 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 and will follow up with a corresponding letter identifying the specific document(s) missing from the record.

E. 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 Documentation (MR1) error. 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.

If the RC receives documentation after the cycle cutoff date, the RC will review the documentation under continued processing only if the request qualifies for continued processing[9] (still within the 75-day timeframe for original requests or within the 14-day timeframe for additional documentation requests).

F. Policy for Handling Lost or Destroyed Documentation

The PERM measurement 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 Federal Emergency Management Agency (FEMA) declared disaster, the SC will drop the claim from the sample, and replace the claim with another randomly sampled claim if time allows. The RC will make determinations in the event of a fire on a case-by-case basis.

[9] See Continued Processing section for more information.

a. 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 Section V.(B.) of this document to the RC within 75 days of the date of the initial written request for documentation from the RC.

b. 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 discard the claim(s) from the sample.

G. POLICY FOR PROVIDERS UNDER FRAUD INVESTIGATION

For claims selected in the PERM sample in which the provider listed is under fraud investigation and the state does not want the RC to contact the provider, the state may notify the RC that the record for a specific provider is not available due to the investigations and the RC will stop all requests for associated records in the sample. PERM does not drop these types of claims from the sample. IPIA requires federal agencies to measure ''improper payments'' and does not distinguish between different types of improper payments (for example, unintentional errors versus fraud). Since the provider cannot submit the record for review, the RC will find a No Documentation Error (MR1) and will report the claim as an error in the final findings.

VI. Data Processing Reviews

The DP review determines whether a claim 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 the claim processed appropriately. Payment requirements include state's documented policies, federal regulations, a HIPAA standard, 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.

The difference in payment between what the state paid and what the state should have paid is the dollar amount of the payment error. A DP error can result in either an overpayment or underpayment.

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
- Payments for services that should have been paid by a third party
- Pricing errors
- Logic edit errors
- Data entry 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, 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 Data Processing Review Components

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

a. 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 level of care, 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

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.

b. Verification of Third-Party Liability Payment 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

c. 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 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 (LEIE)
- State compliance with risk-based screening for providers

d. 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
- Compliance with a HIPAA 5010 transaction standard
- That the claim was submitted with ICD-10-CM codes for claims with DOS on or after October 1, 2015
- 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 co-pays or fees for a service
    - Discounted rates for providers
    - Price reporting elements that form the basis for payment amounts (e.g., Average Wholesale Price , Wholesale Acquisition Cost)
- 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 Managed Care Data Processing Review Components

In order for the RC to determine that the beneficiary was eligible for the capitation payment, the RC reviews the information listed in section A. Basic FFS Data Processing Review Components:

a. Verification of Beneficiary Information

See Section VI.(A.)a. above.

b. Health Plan Contracts

To establish that the capitation paid was correct, the RC reviews the terms of the health plan 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

c. Verification of Health Plan Enrollment

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

d. Correct Payment

The RC determines whether the beneficiary was in the correct rate cell/category based on state policies, 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 60 days of the sampled payment date.

C. DATA PROCESSING ERROR CODES[10]

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. Services on a sampled claim may also conflict with services on another claim during the same DOS.

DP2 – Non-Covered Service/Beneficiary Error: The state's policy indicates that the service billed on the sampled claim is not payable by the Medicaid program or CHIP and/or the beneficiary is ineligible for the coverage category for the service.

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

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

DP4 – Third-Party Liability 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: The system did not contain the edit that was necessary to properly administer state policy or the system edit was in place but was not working correctly and the sampled line item/claim was paid inappropriately.

DP7 – Data Entry Error: The sampled line item/claim was paid in error due to clerical errors in the data entry of the claim.

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

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

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

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

DP12 – Administrative/Other Error: A payment error was discovered during DP review, but the error was not a DP1 – DP11 error or documentation was not provided in order to complete the review.

DTD – Data Processing Technical Deficiency: The claim would have resulted in an improper payment; however, it was a zero paid claim.

VII. Medical Reviews

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 documentation submitted
- 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 Medical Review 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 (e.g., denied claims), specific review procedures may be required. See the PERM claim categories for MR below.

Claim Category 1: Inpatient Hospital Services

- Acute inpatient
- Long-term acute
- Acute inpatient rehabilitation

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

- Inpatient and outpatient psychological, psychiatric, and behavioral health services
- Drug and alcohol inpatient and outpatient services

- Group homes

Claim Category 3: Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICFs)

- Nursing home and convalescent centers
- Chronic care

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

Claim Category 5: Clinic Services

- Hospital-based clinics
- FQHCs
- IHS
- Outpatient RHCs

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
- 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/target 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 (PHPs)
- Claim Category 99: Unknown

B. Process for Conducting the Medical Review

The RC conducts a comprehensive MR on each sampled unit (full claim or line item) for which it receives medical records. This includes reviewing medical record documentation, federal regulations, and state-specific guidelines and 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. Most 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 excludes certain claim categories from a coding review when the payment is not based on procedure codes or DRG payments. These excluded categories include nursing facilities, ICF payments, and pharmacy claims. However, nurse reviewers do validate the NDC for pharmacy claims.

The RC reviews claims for medical errors according to 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). 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.

a. 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.

b. 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.

c. 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.

d. 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). The RC does not perform coding reviews for long-term care payments since claims for these services are not paid based on ICD-10 codes.

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

e. Verification of Appropriate Physician Certification

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

C. Special Rules for Medical Review

a. Underpayments

If reviewers note a discrepancy between the number of units billed and the number of units provided (where the provider billed for less units than were documented), reviewers will require appropriate repricing documentation from the state to determine the appropriate billing amount and will cite the claim as an underpayment error.

b. Date of Service

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

The RC cites the claim with a Medical Technical Deficiency (MTD) with $0.00 error amount for incorrect DOS if both:

- All the other details of the claim are correct (medical record matches the claims details)
- The DOS does not deviate by more than seven calendar days (medical record shows the DOS is no more than seven calendar days before or after the billed DOS)

OR

The RC cites a claim with a payment error if the DOS deviates by more than seven calendar days (medical record shows the DOS are more than seven calendar days before or after the billed DOS)

c. 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 percent 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 the error amount reflects 100 percent 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. Documentation can be screenshots demonstrating the appropriate claim paid amount from the financial system if the claim had been billed correctly.

States can utilize the DR process to formally request repricing or, if that timeframe has expired, states can 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 percent improper payment.

D. MEDICAL REVIEW ERROR CODES[11]

MR1 – No Documentation 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. The provider did not send any documentation related to the sampled payment.

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 Code 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 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.

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

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.

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 – Inadequately 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.

MR 10 – 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: The DOS and billing date are less than seven days different and the claim did not result in a payment error.

VIII. Eligibility Reviews

The purpose of the eligibility case review is to identify improper payments related to the beneficiary's eligibility determination. The eligibility case review focuses on whether a 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
- Memorandums
- Application forms and other standardized forms

The ERC works with the state point of contact 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 they 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. Those include:

- Household composition
- Relationship to applicant
- Age
- Gender
- Citizenship
- Immigration status
- Social Security Number
- 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

a. Case Review Methodology

The eligibility case review includes a review of all relevant caseworker and system actions applicable to the determination and 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.

1. While reviewing caseworker actions, the ERC determines whether the caseworker made the correct determination based on information available at the time of the decision.

2. While reviewing system actions, the ERC determines whether any case decisions were made appropriately by the system and whether the appropriate information was verified through the applicable data sources.

b. 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; however, verifications 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.

c. 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

d. 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

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, the ERC will cite a deficiency. If no redetermination was conducted, the ERC will cite an error.

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

Supplemental Security Income (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 Social Security Administration (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 1972 Social Security Act Amendment 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 in order to receive services. The state then decreases the amount paid to the long-term care institution by that same amount. The contribution to care/patient pay amount is established at the time of the eligibility determination during the verification and calculation of income to determine an individual's eligibility.

The ERC will review the contribution to care/patient pay amount for all relevant sampled cases and work with the RC when necessary. If the calculation is determined to be incorrect, the ERC will communicate with the RC to determine what type of claim was sampled. If the claim was for long-term care, the ERC will cite a partial payment error for 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 claim was not for long-term care, there would not be an error finding because there was no impact to the payment that was sampled.

Eligibility Categories with Different Benefit Packages

Some eligibility categories may cover different services, such as Emergency Services Only categories for enrollees who are 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. If the ERC determines that a beneficiary is in the incorrect benefits package, the ERC will assess whether the difference affected the type of service sampled on the claim. An error will be cited if the service provided is not covered under the correct benefit package. Otherwise, no finding will be cited for benefit package discrepancies that do not result in an inappropriate service provided.

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 Federally-Facilitated Exchange Determination (FFE-D) and FFE Assessment (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 Account Transfer (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.

C. ELIGIBILITY REVIEW ERROR CODES[12]

ER1 – **Documentation to support eligibility determination not maintained; unable to determine 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/documentation not done/collected at the time of 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 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.

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

ER7 – **Not eligible for enrolled eligibility category; resulting in incorrect Federal Medical Assistance Percentage (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, which results in the individual receiving services for which he or she is not eligible.

ER9 – **Federally-Facilitated Exchange Determination (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.

ER-TD1 – **Incorrect case determination, but there was no payment on claim:** There was an issue with the determination that would have resulted in an ER1 – ER10, but no payment was made for the claim.

ER-TD2 – Finding noted with case, but did not affect case determination or payment: The beneficiary redetermination was conducted after the DOS but prior to the date of payment on the claim.

IX. Difference Resolution 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. Difference Resolution 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 Sampling Unit Disposition (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). 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

All DR requests are submitted through SMERF and, if additional documentation is required, it should be sent to the appropriate review contractor. 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.

The deadline for filing an appeal is 15 business days after notification of the DR decision. States must submit all documents to the RC or ERC when requesting DR. 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 DR or appeal to the contractors or CMS.

42 CFR §431.998 Difference resolution 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 SC includes unchallenged error findings in its improper payment rate calculations. DR and appeal results are reflected in the error findings unless the DR or appeal was filed after the cycle cutoff. If a DR or appeal is filed after cycle cutoff, see the Continued Processing section below for more information.

a. Eligibility for Difference Resolution

The following terms and conditions apply to the DR process.

- 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.
- Only one DR can be filed per review type (eligibility, MR, DP). If a claim has multiple errors within a review type, the state must dispute all findings it wishes to dispute at the time the DR is filed.
- States must request DR within 25 business days after the RC publishes the SUD report.
- States do not need to file a DR for MR2 errors or MR errors where the provider is submitting the requested documentation or the state is submitting the information necessary to reprice the claim; however, the state is encouraged to utilize this process if it is still within 25 business days of the SUD.
- 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

b. Repricing Partial Errors during Difference Resolution

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 percent 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 would have priced at 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:

- Procedure Code (MR3) Errors

- Diagnosis Code/DRG (MR4) Errors
- Unbundling (MR5) Errors
- Number of Units (MR6) Errors

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.

a. Notification of CMS Appeal Rights

The RC 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.

b. 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

c. 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.

d. 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.

X. 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 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.

A. Cycle Cutoff

The SC calculates improper payment rates based on information received from states/providers by the cycle cutoff date. Typically, the cycle cutoff date is the second April 15 of a measurement cycle. However, CMS may push back the cycle cutoff date depending on the progress of the cycle.

The RC and ERC review documentation and complete DRs/appeals requests received by the cycle cutoff date for improper payment rate calculation.

The PERM program does not include finding results based on documentation received or DRs/appeals requested after the cycle cutoff date in improper payment rate calculations. However, these instances may be eligible for continued processing.

a. Multiple Errors on One Claim

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.

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*. Thus, if a payment was made and then adjusted more than 60 days later because of a

state-initiated adjustment that was required for programmatic reasons that are unrelated to payment errors, it should not be considered an error in the PERM review.

C. CLAIMS IMPROPER PAYMENT RATE CALCULATION

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

- A FFS payment improper payment rate
- A MC payment improper payment rate
- An eligibility improper payment rate
- A combined improper payment rate (dollar weighted)

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 use 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 strata *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*.

a. 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 $\hat{R}$ is the improper payment rate for FFS, MC, or combined (C) and t_p represents total payments for FFS, MC, or the total, depending upon the subscript of the variable.

b. 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

c. Continued Processing

Continued processing occurs when a claim did not have time to go through the full PERM process before the cycle cutoff date. Examples include:

- Medical records for a claim received after the cycle cutoff date but within 75 days of the initial request for medical records
- An error cited before the cycle cutoff date, when the state's allowable timeframe to request DR and CMS appeal extended beyond the cutoff date

Claims will complete the PERM process through continued processing and CMS will recalculate a state's improper payment rate based on the continued processing results.

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 part of continued processing. However, if a state has documentation 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

the CMS Regional Office (RO) financial contact to determine what adjustment to the expenditure reports is required for recovery purposes.

E. STATE-SPECIFIC IMPROPER PAYMENT RATE RECALCULATIONS

CMS will recalculate a state's improper payment rate under two circumstances:

- A portion of the state's sampled claims underwent continued processing and errors were overturned/error amounts were changed
- A PERM contractor's mistake was identified

CMS will issue recalculated improper payment rates to all states affected by continued processing once continued processing is complete for a cycle. A new state-specific sample size for any affected component will also be calculated based on the recalculated improper payment rate.

A state's improper payment rate is factored into the national rolling improper payment rate for three years. Improper payment rate recalculations will not be included in the first year improper payment rate because the recalculations occur after this number is reported. However, state-specific improper payment rate recalculations will be included in the next two years a state's improper payment rate is included in the rolling rate.

F. 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 50 states and the District of Columbia is first aggregated. This data includes the 17 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 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:

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

Where $\hat{R}_T$ 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 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.

G. 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 cycle states. Then, the cycle improper payment rate is calculated using the component improper payment rates.

The formula for the 17-state component cycle improper payment rate is as follows:

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

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.

XI. Improper Payment Rate Targets

OMB guidance for implementing IPERIA 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 must 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 list the current improper payment rate targets.

B. State-specific Improper Payment Rate Targets

The national Medicaid improper payment rate is 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 1.5 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	12.4%	0.3%	N/A	
Anchor Rate	1.5%	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	7.0%	0.3%	3%	7.2%*

* 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.

C. 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 sample sizes and improper payment rate targets for the state's next PERM cycle

Cycle Summary report: 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 template: This template 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

XII. Corrective Action Process

The PERM corrective action process is administered and supported by the Center for Program Integrity (CPI), through the Division of State Partnership (DSP). A DSP PERM CAP team has been established to support state efforts to reduce the improper payment rates in the Medicaid program and CHIP.

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

CMS provides guidance to state contacts on the CAP process upon publishing the PERM improper payment rates and throughout the CAP development process until the CAP specified due date, which is 90 calendar days after the state's improper payment rates are posted on the CMS contractor's website (SMERF).

The 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 error causes, trends in errors, or other vulnerabilities to reduce improper payments. The state's current year CAP must also include an evaluation of its previous CAP. Through the CAP process, states are able to document actions they will take to reduce errors that cause improper Medicaid and CHIP payments.

The state must submit the CAP to their assigned DSP Liaison within 90 calendar days after the date on which the RC posts its improper payment rates on SMERF. For more information about the CAP process, please email PERMCAPS@cms.hhs.gov.

XIII. 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 Part 433 subpart F and for CHIP under section 2105(c)(6)(B) and 2105(e) of the Act and 42 CFR Part 457 subpart B and 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 Final Errors for Recovery (FEFR) reports on SMERF and 2) by receiving an official letter with "notification of an overpayment" via email.

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 continued processing reviews, 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 regulations at 42 CFR Part 431, subpart P.

A. Final Errors For Recovery Report

The RC posts each state's FEFR report on SMERF at the end of the cycle, after it completes continued processing and finalizes all findings for the state for that cycle. The FEFR report serves as the final list of overpayments for which a state must return the federal share for a PERM cycle. The report includes the total computable amount of all overpayments for the cycle and 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 Regional Office contacts. States are only required to recover the federal share 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.

a. 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 Regional Office contact and provide documentation (e.g., screenshots, etc.) 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 Regional Office 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 Documentation (MR1) and Document(s) Absent from Record (MR2) errors]. Since this occurs after the cycle cutoff date, 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 PERM State Liaison through a password protected and encrypted CD. <u>As a reminder, please do not send PII nor PHI information through email.</u> CMS' PERM appeals panel reviews the documentation to determine if it demonstrates the state correctly paid the claim.

Any request for recoveries exceptions must be based on one of the above reasons and must be submitted to CMS within three months after the publication of the FEFR in order for CMS to consider the information.

b. 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.

XIV. Appendices

A. GLOSSARY

Account Transfer (AT) file: The electronic file of applications transferred to the state's Medicaid or CHIP agency from the 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 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 where 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 claim. An adjusted claim can be linked to the original claim.

Administrative Services Only (ASO): 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 Act.

Agency Financial Report (AFR): Annual report published by HHS that provides fiscal and high-level performance results of agency activities, including Medicaid and CHIP improper payment rates.

Annual sample size: The number of FFS claims or lines or MC capitation payments necessary to meet precision requirements in a given PERM cycle.

Beneficiary: The recipient of Medicaid or CHIP benefits.

Capitation: A previously determined (fixed) payment, usually made on a monthly basis, for each beneficiary enrolled in a 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 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 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 of applications or redeterminations, processing changes to applications or redeterminations, and verifying applicant information and is not action automatically completed by the system.

Children's Health Insurance Program (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 CFR Part 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.

Data Processing (DP) error: A payment error that can be determined from the information available on the claim or from other information available in the state Medicaid/CHIP claims processing system (exclusive of MR and eligibility review).

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, and 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 Review Contractor (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.

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 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 payment.

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, 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.

Federally-Facilitated Exchange (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

Federally-Facilitated Exchange 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.

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

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 Tax Information: Information contained on an individual's federal tax return.

Fee-For-Service (FFS): A traditional method of paying for medical services by which a state pays providers for each service rendered.

Finite population correction factor: A statistical calculation that the state or the SC may employ to determine sample sizes as an alternative to the base rates when sampling programs in which the total (full year) sample is drawn from a population of less than 10,000 individuals/claims.

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 IPERIA of 2012 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 sum of the overpayments and underpayments in the sample; that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

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 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 reinsurance payments are those payments made by the state to a 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 a 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.

Managed Care (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.

Managed Care Organization (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.

Medical Review (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.

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.

Minimum Essential Coverage: Qualifying health care coverage that meets the individual shared responsibility provision in the Affordable Care Act.

Modified Adjusted Gross Income (MAGI): The new method implemented under the Affordable Care Act of calculating income eligibility for Medicaid, CHIP, and financial assistance available through the Health Insurance Exchange. The calculation generally does not apply to ABD (non-MAGI) populations.

Modified Adjusted Gross Income (MAGI) 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).

Non-claims based sampling unit: Sampling units not related to a particular service provided, such as Medicare Part A or Part B premiums.

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

No touch: Refers to a case that is processed only by the eligibility system and does not have manual work or caseworker action performed on it. For example, passive redeterminations may be automated and not involve a caseworker.

Overpayment: Overpayments occur when Medicaid or CHIP pays more than the amount the provider was entitled to receive or more than its share of the cost.

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

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

Patient liability: The term used by the Medicaid program to refer to the Medicaid beneficiary's financial obligation toward the cost of care each month.

Payment: Any payment to a provider, insurer, or MCO for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP FFP. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulations or policy.

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 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.

Post-Eligibility Verification: Practice where a state subsequently verifies eligibility criteria after granting an individual coverage based on the information he/she attested.

Premium: Cost-sharing amount that a beneficiary is responsible for paying for enrollment in Medicaid or CHIP.

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): A benefit that states may choose to offer to Medicaid beneficiaries age 55 or older in an effort to keep individuals in the community who would otherwise be determined to require the level of care provided by a nursing facility. Qualifying beneficiaries receive all Medicaid-covered services through their PACE provider. States pay PACE providers on a capitation basis. PACE providers must meet minimum federal standards.

Provider error: This includes, but is not limited to, MR errors as described in 42 CFR 431.960(c), as determined in accordance with documented state or federal policies, or both.

Qualified Medicare Beneficiary: Individuals entitled to Medicare Part A, who have income of 100 percent Federal Poverty Level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility. Can be received in conjunction with full Medicaid.

Redetermination: Case action in which an individual who is currently enrolled in Medicaid or CHIP is evaluated again to determine if s/he continues to be eligible for coverage under either Medicaid or CHIP either at the time of renewal or when a change in circumstances is reported.

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 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.

Risk-based MC: The MCO assumes either partial or full financial risk. The payer pays the MCO a fixed monthly premium per beneficiary.

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: A random sample of claims selected from a universe (see "universe" definition below).

Sampling unit: The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, a month of enrollment in a MC plan, or a monthly Medicare premium). Depending on the universe (i.e., FFS or MC), the sampling unit may include claim, line item, premium payment, or capitation payment.

Self-Attestation: The policy that allows beneficiaries to indicate that they meet certain, state-selected eligibility criteria without providing documentation. The state will verify the self-attested information through the use of data sources.

Self-Declaration: The policy that allows beneficiaries to indicate that they meet certain, state-selected eligibility criteria without providing documentation or having the information verified.

Specified Low-Income Medicare Beneficiary: Individuals entitled to Medicare Part A, who have income greater than 100 percent FPL, but less than 120 percent FPL, and resources that do not exceed twice the limit for SSI eligibility and are not otherwise eligible for Medicaid.

Social Security Administration (SSA): The federal agency that administers Social Security programs and makes determinations for Medicaid eligibility for 1634 states**.**

Spenddown: A Medicaid Medically Needy eligibility group for certain individuals who have resources below the Medicaid-eligibility limit, but income above the Medicaid-eligible limit that must be spent on medical bills before qualifying for Medicaid for a specified period.

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

State Plan Amendment (SPA): An amendment to a Medicaid or CHIP state plan that describes changes to how that state administers its Medicaid program or CHIP.

State-Based Exchange: A state-run health insurance marketplace that allows individuals to apply for insurance affordability programs, including Medicaid and CHIP.

State error: This includes, but is not limited to, DP errors and eligibility errors as described in 42 CFR 431.960(b) and (d), as determined in accordance with documented state or federal policies or both.

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

Stop-loss: See "Individual Reinsurance," above.

Supplemental Nutrition Assistance Program: The program offering nutrition assistance to eligible, low-income individuals and families.

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.

Supplemental Security Income (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.

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

Technical Deficiency: An identified instance of noncompliance with 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).

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.

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): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. In cases of available TPL, Medicaid is the payer of last resort.

Title IV-E (Foster Care): A program authorized by Title IV-E of the Act, as amended, and implemented at 45 CFR parts 1355, 1356, and 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 XIX of the Act, as amended, and implemented under 42 CFR that provides health coverage to children with resource needs.

Touch: Refers to a case having manual work or caseworker action performed on it.

Underpayment: Underpayments occur when the state pays less than the amount the provider was entitled to receive based on existing policy and contracts.

Universe (Claims): The universe is the set of sampling units from which the sample for a particular program area is drawn and the set of payments for which the improper payment rate is inferred from the sample. The PERM program uses the term "claim" interchangeably with the term "sampling unit."

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
CD	Compact Disc
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CM	Clinical Modification
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
DME	Durable Medical Equipment
DOS	Date Of Service
DP	Data Processing
DR	Difference Resolution
DRG	Diagnosis-Related Group
DSP	Division of State Partnership
DUA	Data Use Agreement
ELE	Express Lane Eligibility
ePHI	electronic Protected Health Information
ERC	Eligibility Review Contractor
esMD	electronic submission of Medical Documentation
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

Acronym	Definition
FFS	Fee-For-Service
FIPS	Federal Information Processing Standards
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FR	Federal Register
FTC	Federal Trade Commission
FY	Fiscal Year
GRS	General Record Schedule
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
IHS	Indian Health Services
IID	Individuals with Intellectual Disabilities
IPERA	Improper Payments Elimination and Recovery Act
IPERIA	Improper Payments Elimination and Recovery Improvement Act of 2012
IPIA	Improper Payments Information Act of 2002
LEIE	List of Excluded Individuals and Entities
MAGI	Modified Adjusted Gross Income
MC	Managed Care
MCO	Managed Care Organization
MEQC	Medicaid Eligibility Quality Control
MMIS	Medicaid Management Information Systems
MPL	Master Policy List
MR	Medical Review
MRR	Medical Record Request
MSP	Medicare Secondary Payer
MTD	Medical Technical Deficiency
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NIST	National Institute of Standards and Technology
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

Acronym	Definition
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PII	Personally Identifiable Information
RC	Review Contractor
RHC	Rural Health Centers
RO	Regional Office
RSDI	Retirement, Survivors, and Disability Insurance
RY	Reporting Year
SC	Statistical Contractor
SHO	State Health Official
SMERF	State Medicaid Error Rate Findings
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

C. MEDICAL RECORD REQUEST SAMPLE LETTER

Payment Error Rate Measurement Program
CMS PERM Review Contractor, NCI Inc.
1538 E. Parham Road
Henrico, VA 23228

[||Provider Name||]
ATTN: [||Contact Name||], [||Contact Title||]
[||ContactAddress1||] [||ContactAddress2||]
[||Contact City||], [||Contact State||] [||Contact Zip code||]

Date: [||Request_Date||]
Reference ID: [||PERM ID||]
OMB Control Number: [||OMB#||]
NPI: [||NPI#||]

Request Type & Purpose: Initial Request for Records (First Request)
Subject: Records Request – This is an initial request for records

Dear Medicaid and/or CHIP Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the states, is measuring improper payments in Medicaid/CHIP under the Payment Error Rate Measurement (PERM)[1] program. Additional information about the PERM program is addressed on the CMS PERM website (www.cms.gov/PERM). Refer to the "Providers" link on the website.

Reason for Selection: A claim submitted by or on behalf of you/your organization has been randomly selected for review under this program by CMS' review contractor, NCI Inc.

Action: A Copy of Original Documentation Required: Federal regulations require that you provide the medical record documentation to support claims for Medicaid/CHIP services upon request. The pages that follow provide identifying information for the claim selected for review, requested documentation, and submission instructions. Please submit documentation as soon as possible, but no later than the due date provided below. A response is required by the due date even if you are unable to locate requested documents. Providing medical records for Medicaid/CHIP patients does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request. CMS and its contractors will comply with the Privacy Act and regulations.

When: [||MedrecDueDate||]
Please provide the requested documentation by [||MedrecDueDate||]. A response is still required by [||MedrecDueDate||] even if you are unable to locate the requested information.

Consequences: If you fail to deliver the requested documentation or contact us by [||MedrecDueDate||], your state agency may pursue recovery of payment for this claim.

Instructions: The pages that follow provide identifying information for the claim selected for review, requested documentation, and submission instructions. Should you require additional information or have questions, please call our Customer Service Representatives at (800) 393-3068, our Medical Records Manager at (804) 888-8341, or your state PERM representative, _____, at _____ or _____.

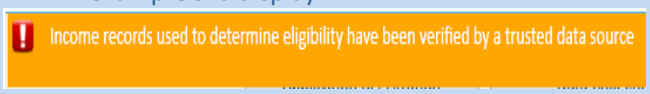
Note: Starting in February 2020, the PERM Review Contractor's name will appear in communications as NCI Inc. rather than AdvanceMed, an NCI company. This change is due to a corporate rebranding initiative and is a change in name only.

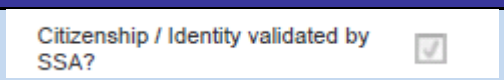
[1] Social Security Act Section 2107(b)(1) [42 CFR §431.950 et seq]; 45 CFR parts 160 and 164

D. DOCUMENT REQUIREMENTS TABLE

Overall Documentation Requirements

Documentation	Audit Trail for Reviewers	Questions for State
Signed Application / Redetermination Form	**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 ex parte or passive renewal process. The original application or redetermination form, if applicable, may be electronic or hard copy, but should include a record of the information the applicant submitted and the applicant's signature. The type of documentation that must be maintained to verify the signature varies by the channel of the application. These channels are specified below. 1. ***If a paper application/redetermination form was filed:*** A paper application/redetermination form must be signed under penalty of perjury with a handwritten signature. 2. ***If a fax application/redetermination form was filed:*** A fax application/redetermination form must be signed under penalty of perjury with a handwritten signature. 3. ***If an electronic application/redetermination form was filed:*** An electronic application/redetermination form must be signed under penalty of perjury with an electronic signature. An example of an electronic signature: ✓ By checking this box and typing my name below, I am electronically signing my application. Person's Name Date 4. ***If a phone application/redetermination form was filed:*** 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 recorded signature. Signatures and redetermination forms are not required on passive or ex parte renewals.	• How are original applications/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
Electronic Verification	**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. ***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.* *For system indicators to be acceptable, they must be automatically generated. Indicators manually updated are not acceptable proof of electronic verification.* ***Examples of acceptable indicators within an eligibility system:*** 1. The state's eligibility system displays information that the electronic data match occurred. An example of a display:  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. An example of a verification page with pass/fail status: **Verification Element** — **Verification Status** Citizenship — Pass SSN — Pass Income — Fail An example of a verification page with verified/not verified status: **Verification Element** — **Verification Status** Citizenship — Verified SSN — Verified Income — Not Verified 3. The state's eligibility system contains a check box where a check appears when a data match occurred. An example of a check box:	• 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.

Documentation	Audit Trail for Reviewers	Questions for State
	 4. The state's eligibility system provides more detailed information related to the electronic data match. Examples of indicators that contain detailed information about the electronic data match: **Verification Information for ID=SOM1HUB104170729SSA** 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 **Verification Information for ID=DHSIncomeVerified** 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	
Case Comments	**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. <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].	• 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?

Documentation Requirements for each Eligibility Criteria (Element)

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
Citizenship	**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.) ***If verified electronically:*** There must be an indicator in the eligibility system associated with the action under review showing that citizenship was verified per federal requirements. ***If verified in hard copy documentation:*** The state must have a record of the hard copy documentation used. Examples of allowable hard copy documentation include: 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	• 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?
Immigration Status/ Non-citizens	**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. ***If verified electronically:*** 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 Report may be maintained in the system. ***If verified in hard copy documentation:*** The state must have a record of the hard copy documentation used. Examples of allowable documentation (copies permitted) include: 1. Permanent Resident Card 2. Refugee or Asylee documentation	• 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
State Residency	***If self-attestation accepted:*** 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. ***If self-attestation not accepted:*** ***If verified electronically:*** 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. ***If verified via hard copy documentation:*** The state must have a record of the hard copy documentation used. Examples of allowable hard copy documentation include: 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	• 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?
Social Security Number	**What PERM needs to see:** An indicator or hard copy documentation showing that social security number was appropriately verified at the time of determination or post determination if the state conducts post-enrollment verification. ***If verified electronically:*** There must be an indicator in the eligibility system associated with the action under review showing SSN was verified by the SA. ***If verified via hard copy documentation:*** The state must have a record of the hard copy documentation used. Examples of allowable hard copy documentation include, but are not limited to: 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	• 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
Age/Date of Birth	***If self-attestation accepted:*** If self-attestation is accepted per the state's verification plan, a signed application can be utilized to verify self-attestation. ***If self-attestation not accepted:*** There must be an indicator in the eligibility system associated with the action under review 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. ***If verified via hard copy documentation:*** The state must have a record of the hard copy documentation used. Examples of allowable hard copy documentation include: 1. Birth Certificate 2. U.S. State Vital Statistics record 3. Hospital Birth Records	• 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?
Pregnancy	States must accept self-attestation for pregnancy. A signed application or redetermination form or other self-attested document 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.	• Is this information clearly available on the application?

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
Household Size	***<u>If self-attestation accepted:</u>*** 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. ***<u>If self-attestation not accepted:</u>*** ***If verified electronically:*** 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. ***If verified via hard copy documentation:*** The state must provide the hard copy documentation used. Examples of allowable hard copy documentation include, but are not limited to: 1. Birth certificates 2. Adoption papers or records 3. Marriage licenses 4. Divorce papers 5. Court records of parentage	• 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?
Blindness, Disability, Medical Eligibility/Level of Care)	**<u>If determined by state agency</u>:** The state must provide the state-specific Medical Review Team or other authorized entity's approval form or a comparable eligibility screenshot that shows elements like approval, decision date, and other relevant information. **<u>If determined by the Social Security Administration</u>:** The state must provide PERM reviewers proof that the beneficiary is enrolled in the program for which the disability or blindness determination was determined. Examples include hard copy documentation or electronic proof of enrollment in the program for which disability or blindness was determined. Proof includes: 1. Receipt of RSDI (benefits on the basis of disability) as of the DOS. 2. Receipt of SSI benefits based on disability or blindness as of the DOS.	• 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/level of care documentation be made available to the reviewer?

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
Earned and Unearned Income	**What PERM needs to see:** An indicator or hard copy documentation showing that earned and unearned income was appropriately verified. ***If verified electronically:*** 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. ***If verified via hard copy documentation:*** 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. **Documentation must be available for each type of income including, but not limited to, the following:** • 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)	• Does your state verify income pre- or post-eligibility? • What will reviewers see in your state? • If your state is post-eligibility, what is the timeframe that the eligibility determination must be made? • Is there any situation where your state is not utilizing electronic data sources to verify income? • 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? • 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?

Eligibility Criteria (Element)	Audit Trail for Reviewers	Questions for State
Resources/Assets (non-MAGI cases)	**What PERM needs to see:** An indicator or hard copy documentation showing that resources/assets were appropriately verified, if applicable. ***If verified electronically:*** There must be an indicator, documentation from the asset verification system, or detailed case comments to indicate that electronic verification was performed. ***If verified via hard copy documentation:*** The state must provide the hard copy documentation used. **Documentation must be available for each type of resource/asset including, but not limited to:** • Bank Accounts/Financial Resources • Property • Vehicle • Trusts/Annuities • Life Insurance • Funeral/Burial Trusts/Plots	• What will reviewers see in your state? • Does your state have an Asset Verification System (AVS) or have plans to implement an AVS in the future? • 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? • Are there situations in which the state accepts self-attestation of resources for renewals?
TPL (e.g., Private Health Insurance)	**What PERM needs to see:** An indicator or hard copy documentation showing that health insurance was appropriately verified, if applicable. ***<u>If self-attestation accepted:</u>*** If self-attestation is accepted per the state's verification plan, a signed application or redetermination form can be utilized to verify self-attestation. ***<u>If self-attestation not accepted:</u>*** ***If verified electronically:*** 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. ***If verified via hard copy documentation:*** The state must provide the hard copy documentation used.	• 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	**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 "Electronic Verification" row in "Overall Documentation Requirements" table above). Similar to initial applications and other redeterminations, the state must be able to show the eligibility system verified income and other required eligibility elements (e.g., indicator in the system) through electronic sources.	• 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	**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.) 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 43 CFR 435.603(f).	• How does the state ask for tax filing status and how can this documentation be provided to the reviewers?
Reported Changes by Beneficiary	**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.	• What will reviewers see in your state when a beneficiary reports changes? • How does your state document beneficiary-reported changes?
Title IV-E cases	**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 state does not need to provide support for the underlying Title IV-E eligibility. <u>Examples of Title IV-E documentation:</u> 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.	• 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
SSI Cases – 1634 states	**What PERM needs to see:** If a state is a 1634 state, the state must provide proof that the individual was eligible for SSI as of the DOS of a sampled claim. The underlying eligibility of SSI will not be reviewed. Examples of documentation for SSI decisions of 1634 states: 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 Beneficiary Data Exchange (BENDEX) system record	• 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?
Presumptive Eligibility by Qualified Entities	**What PERM needs to see:** Documentation showing that the state received information from qualified entity to enroll the individual. Presumptive eligibility documentation may include: 1. Correspondence and notifications between the state and the qualified entity and when the state received the notification.	• 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?
Cases from the FFE	**What PERM needs to see:** The AT file or another document showing the information in the AT file. Determination and Assessment states will be asked to provide AT files to the ERC. 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.	• In what format are the AT files maintained? • Who maintains the AT files in your state?

Version Control Updates

Date	Version	Description of Changes and Updates	Author
July 12, 2013	1.0	Added version control table, updated where appropriate to 2012 language, added DP, MRR, MR updates to August 30, 2012 CMS PERM Manual	A+ PERM Team (LCH, CM, MB,SK, AK)
October 15, 2013	1.1	Made updates to Introduction (Section 10) and Claims and Sampling (Section 20), Eligibility Universe and Sampling (Section 30), Eligibility Reviews (Section 80), Error Code Table (Section 100), incorporated CMS edits, updated where appropriate to 2014 language	Lewin (JM, AH)
January 27, 2015	1.2	Made updates to the RC sections of the manual	A+ PERM Team (LCH, MB, SK)
August 2015	1.3	Overall updates to content and formatting, including removal of eligibility reflective of FY14- 17 pilots	A+, Lewin, CMS
September 2016	1.4	Overall updates to content	CNI, Lewin, CMS
January 2017	1.5	Overall minor updates to content	CMS, Lewin
July 2017	1.6	Overall updates to content	CNI
December 2017	1.7	Overall updates to content	CMS
April 2018	1.8	Overall updates to content	CMS, Booz Allen, CNI, Lewin
May 2018	1.9	Updates to the PERM Sampling Process text	Lewin
January 2019	2.0	Overall updates to content	CMS, Lewin
February 2020	Final	Updates to content and organization. Will need 508 compliance review.	CMS