



The Standard Operating Procedure for States' Role in the Payment Error Rate Measurement (PERM) Program

December 2017

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Glossary

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 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 submitted claim. An adjusted claim can be linked to the original claim.

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

Annual sample size: The number of Fee-For-Service (FFS) claims or lines or managed care payments necessary to meet precision requirements in a given PERM cycle.

Beneficiary: A recipient of Medicaid program or CHIP benefits.

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

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 Social Security Act (the Act).

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.

Claims 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 managed care plan or a monthly Medicare premium). Depending on the universe (i.e., FFS or managed care), the sampling unit includes claim, line item, premium payment, or capitation payment.

Continued processing: Continued processing occurs when a claim did not have the time to go through the full PERM process before the cycle cutoff date. These claims may complete the PERM process through continued processing and the Centers for Medicare & Medicaid Services (CMS) will recalculate a state's improper payment rate based on the continued processing results.

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

Cycle: The 17-state three-year rotation used to measure improper payments.

Cycle cutoff date: This is the last date of the PERM cycle the Review Contractor (RC) will accept information from the states/providers. Documentation received or Difference Resolution (DR) or Appeals requested after the cycle cutoff date are not included in the national improper payment rate calculations. However, these instances may be eligible for continued processing. Typically, the cycle cutoff date is the second July 15 of a measurement cycle. However, the cycle manager may push back the cycle cutoff date if warranted.

Cycle rate: The improper payment rate for the 17 states measured in the current cycle.

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

Data Processing (DP) error: A payment error that DP reviewers can determine from the information available from the claim or from other information available in the state Medicaid/CHIP claims processing system (exclusive of medical records).

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

Deficiencies: A technical deficiency is a review finding indicating that a problem existed with the claim or medical record but did not affect payment. These are \$0 errors and have no impact on the improper payment rate.

Denied claim or line: A denied claim or line item is one 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.

Difference Resolution (DR): A process that allows states to dispute the RC’s error findings.

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

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

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

Improper payment: An improper payment is defined by the Improper Payments Elimination and Recovery Improvement Act (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 recipient 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.

Managed care: A system in which 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.

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.

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.

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.

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

Payment: Any payment to a provider, insurer, or managed care organization for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP Federal Financial Participation (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 <https://www.cms.gov/PERM>.

PERM+: A claims and payment data submission method through which the state submits claims, provider, and beneficiary data to the Statistical Contractor (SC). The SC uses the data to build sampling universes from which it selects a sample of claims. After selecting the samples, the SC sends the samples to the RC 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.

PERM Technical Advisory Group (TAG): A forum established to discuss technical and operational issues and to share best practices relating to the PERM program. The TAG includes the Payment Accuracy & Reporting Group (PARG) Deputy Director, the PERM team, state Medicaid Directors, CHIP Directors, and state personnel (such as managers, supervisors, and program integrity directors).

Review Contractor (RC): CMS contractor responsible for collecting state policies and medical records, conducting DP reviews and Medical Reviews (MRs), hosting and maintaining the State Medicaid Error Rate Findings (SMERF) system and assisting with preparation of states' Cycle Summary Reports and the Final PERM Report.

Rolling rate: The official Medicaid program and CHIP improper payment rates that include findings from the most recent three cycles to reflect findings from all 50 states and the District of Columbia. Each time

CMS measures a group of 17 states under PERM; CMS drops the previous findings for that group of states from the rolling rate calculation and adds the newest findings.

Sampling Unit Disposition (SUD) reports: Reports the RC generates on the 15th and 30th of each month during the review phase of the cycle that include DP and MR results.

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

State Systems Workgroup (SSW): A collaborative group consisting of CMS, the PERM SC, the PERM RC, the Regional Offices (ROs), and the states to address state system issues. This group works together to determine the underlying problems and discuss how the issues can be resolved.

Statistical Contractor (SC): Collects and samples FFS claims and managed care capitation payment data, and calculates state and national improper payment rates.

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

Zero-paid claim or line: A zero-paid claim or line is one 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 third-party liability, application of deductibles and patient liability, or other causes.

Introduction

Purpose

The purpose of this Standard Operating Procedure (SOP) is to provide direction and consistent instructions to state personnel regarding states' responsibilities during the Payment Error Rate Measurement (PERM) process. This SOP serves as a reference guide for the PERM program by clarifying the parties' roles and responsibilities, and the processes in place to ensure the timely and accurate performance of critical tasks. Subsequent sections of this SOP address each state's specific PERM requirements in more detail.

Overview of PERM Process

The purpose of the PERM program is to produce a national-level improper payment rate for Medicaid and the Children's Health Insurance Program (CHIP) in order to comply with the requirements of IPERIA.

The PERM program estimates improper payment rates for the Medicaid program and CHIP by reviewing the FFS, managed care, and eligibility components of Medicaid and CHIP in the FY under review. It is important to note that the PERM improper payment rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements. The PERM program will not conduct a full-scale eligibility review in the FY 2017 cycle; however, it will conduct a pilot eligibility review.

On behalf of CMS, federal contractors' measure Medicaid's and CHIP's FFS and managed care components. The PERM program uses a three-year rotation to produce and report national Medicaid and CHIP improper payment rates. Each PERM cycle examines the Medicaid program and CHIP of each of the 17 states. The contractors calculate improper payment rates for each state based on its ratio of projected dollars of improper payments to the dollars of total payments, and then combine the individual state improper payment rates for each component (FFS and managed care) to estimate the national component improper payment rates. To calculate the national program improper payment rates for Medicaid and CHIP, the contractors combine the national component improper payment rates within each program.

Exhibit 1: Medicaid and CHIP Measurement Cycles

Cycle	Includes Payments from These Fiscal Years	States
One	FY 2009 FY 2012 FY 2015 Reporting Year 2019	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Two	FY 2010 FY 2013 FY 2016 Reporting Year 2020	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Three	FY 2011 FY 2014 FY 2017 Reporting Year 2021	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

The national improper payment rate is termed the national rolling rate because the latest individual state projected improper payments and total payments from all 50 states and the District of Columbia are included in the calculation. The contractors ensure the national rolling rate includes all 50 states and D.C. by using results from the three most recently completed cycles. Since eligibility review is on hold in FY 2017, the national rolling improper payment rate will contain the frozen eligibility improper payment rate from the states’ most recent PERM cycle that included eligibility measurement. The state-specific improper payment rates will be comprised of state Medicaid and CHIP claims improper payment rates.

Each PERM cycle begins with a pre-cycle in August of the FY preceding the study year and concludes 28 months later when the improper payment rates are calculated and published in the AFR.

Exhibit 2: PERM Cycle Estimated Timeline

Timeframe	Event
January 15	<ul style="list-style-type: none"> ▪ Routine PERM state submits Q1 (October – December) PERM-compliant claims universes to the SC ▪ PERM+ state submits Q1 (October – December) “raw” claims, beneficiary, and provider data to the SC
January – April	<ul style="list-style-type: none"> ▪ State responds to the SC’s data and program-specific questions to help the SC to resolve any issues that may be identified with the Q1 PERM submission ▪ PERM+ state provides guidance to the SC to build PERM universes ▪ SC selects a sample from each of the Q1 universes
Within 2 weeks of sample selection	<ul style="list-style-type: none"> ▪ Routine PERM state submits Q1 PERM details data to the SC ▪ SC creates Q1 details files for PERM+ state
April 15	<ul style="list-style-type: none"> ▪ Routine PERM state submits Q2 (January – April) PERM-compliant claims universes to the SC ▪ PERM+ state submits Q2 (January – April) “raw” claims, beneficiary, and provider data to the SC
April – June	<ul style="list-style-type: none"> ▪ State responds to the SC’s data and program-specific questions to help the SC to resolve any issues that may be identified with the Q2 PERM submission ▪ SC selects a sample from each of the Q2 universes
Within 2 weeks of sample selection	<ul style="list-style-type: none"> ▪ Routine PERM state submits Q2 PERM details data to the SC ▪ SC creates Q2 details files for PERM+ states
April – December	<ul style="list-style-type: none"> ▪ State assists the RC to establish and conduct DP review orientation visits and on-site or remote DP reviews
March – August	<ul style="list-style-type: none"> ▪ RC researches and obtains state’s policies from relevant web sites and conducts general education webinars with states
July	<ul style="list-style-type: none"> ▪ RC begins DP reviews at the state or remotely
July 15	<ul style="list-style-type: none"> ▪ Routine PERM state submits Q3 (May – June) PERM-compliant claims universes to the SC ▪ PERM+ state submits Q3 (May – June) “raw” claims, beneficiary, and provider data to the SC
July – September	<ul style="list-style-type: none"> ▪ State responds to the SC’s data and program-specific questions to help the SC to resolve any issues that may be identified with the Q3 PERM

Timeframe	Event
	submission <ul style="list-style-type: none"> SC selects a sample from each of the Q3 universes
Within 2 weeks of sample selection	<ul style="list-style-type: none"> Routine PERM state submits Q3 PERM details data to the SC SC creates Q3 details files for PERM+ states
May – June	<ul style="list-style-type: none"> State assists the RC to establish and conduct SMERF web site orientations/training via conference call/webinar
September	<ul style="list-style-type: none"> RC begins MR MR continues for the remainder of the cycle as medical records are submitted by providers
October 15	<ul style="list-style-type: none"> Routine PERM state submits Q4 (July – September) PERM-compliant claims universes to the SC PERM+ state submits Q4 (July – September) “raw” claims, beneficiary, and provider data to the SC
October – December	<ul style="list-style-type: none"> State responds to the SC’s data and program-specific questions to help the SC to resolve any issues that may be identified with the Q4 PERM submission SC selects a sample from each of the Q4 universes
Within 2 weeks of sample selection	<ul style="list-style-type: none"> Routine PERM state submits Q4 PERM details data to the SC SC creates Q4 details files for PERM+ states
July 15 (of the following year)	<ul style="list-style-type: none"> Typical CMS cycle cutoff date
September (of the following year)	<ul style="list-style-type: none"> RC submits final findings to the SC SC calculates improper payment rates
November (of the following year)	<ul style="list-style-type: none"> National rates published in the AFR State notified of state rates and preliminary sample sizes for the following cycle
Throughout PERM process	<ul style="list-style-type: none"> State assists the SC and the RC with clarification about the universe, samples, and details State identifies and resolves differences in review findings with the RC
November through February (of the following year)	<ul style="list-style-type: none"> The CAP is due 90 days after the state-specific rates are issued

Summary of State Responsibilities during Claims Intake Process

- ▶ Submit completed Universe Data Survey and data dictionary by August 15th
- ▶ Ensure state personnel best able to respond to Intake Protocol questions attend the Intake Meeting (do not substitute attendance with written responses)
- ▶ Review and comment on Intake Notes within 14 days of receiving them from the SC

Claims Universe Data Submission

For the federal FY under review, states should submit universe data to the SC by the 15th day after the end of each quarter (or the next business day if the 15th is on a weekend). Thus, Quarter 1 universe data are due on January 16, Quarter 2 universe data on April 17, Quarter 3 universe data on July 17, and

Quarter 4 universe data on October 16. States must let the SC know as soon as possible if they foresee a delay in submission.

The SC's systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, portable hard drives). The SC prefers that the state send its data via Secure File Transfer Protocol (SFTP). However, if this is not possible, the state may submit data in an encrypted CD or DVD. Do not send PERM data to the SC via email. The SC will send each state details on how to transmit data via the SFTP prior to the date of the first universe submission. For enhanced security, the PERM SFTP now uses a two-factor authentication before allowing users to access the site. State personnel submitting data should carefully read the SFTP instructions and test SFTP access prior to data submission deadlines.

The SC is capable of receiving data in a number of formats. Please refer to the Universe Data Submission Instructions for more detailed information on these formats. The state should also ensure that the universe data align with the specifications provided to the SC during the intake discussions. For example, if a state informs the SC that it will submit its pharmacy claims at the line level, the state should ensure its data complies with this representation. Otherwise, it must notify the SC of any inaccurate information it provided during the intake discussion. The state should also ensure that it submits all payment and claims data subject to PERM review from off-Medicaid Management Information Systems (MMIS), waiver programs, and vendors (e.g., PBM) to the SC each quarter.

Universe Quality Control Process

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

Data Standardization

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

Data Validation

- ▶ The control totals in terms of the number of lines and the total paid amount the state provides in the Transmission Cover Sheet during data submission matches the control totals the SC calculates.
- ▶ The claims data contain core fields and each field contains valid values that are listed in the data dictionary.
- ▶ For the Routine PERM states, the data do not contain adjustments, information-only lines, state-only payments, and other payments/records that are not subject to PERM review. For the PERM+ states, the data may contain these exclusions; however, the SC will request the state's confirmation prior to removing them from the universe.

- ▶ There is a reasonable and expected distribution of payment units and amounts by claim type, provider type, paid date, and across quarters.
- ▶ Each record contains valid values for Internal Control Number/Transaction Control Number (ICN/TCN), paid amount, paid date, claim type, payment level, and provider type.
- ▶ There are no duplicate records, negative paid amounts, denials associated with non-zero payment amounts, paid dates outside the quarter, or missing lines for claims paid at the line level.
- ▶ The submitted data reflect information the state provided during the Intake Meeting, in state documentation, and in other communication.

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

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

The PERM QC process involves SC review of multiple points in the process to ensure: adherence to all PERM specifications; the sample is selected from a complete, correct and compliant universe; each PERM record has one and only one chance of being sampled; and the sample and details data contain all the necessary information for efficient DP and MR.

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

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

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

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

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

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

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

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

Sample Selection

The SC draws a random sample of claims from the quarterly Medicaid FFS, CHIP FFS, Medicaid managed care, and CHIP managed care universes from the data the states submit. The SC shares its sampling methodology with the state in the pre-cycle phase. The annual sample sizes for Medicaid and CHIP FFS and Medicaid and CHIP managed care are state-specific based on the prior cycle's improper payment rates and margins of error. The state receives a copy of the sample once selected. A CMS regulation prohibits the PERM contractors from releasing the sample until 60 days have passed following the end of the quarter. Therefore, if the SC selects a sample within the 60-day timeframe, the SC will share the sample with the RC, but not with the state until the 60-day period is over.

The SC draws the claims samples as soon as it receives all the universe data and completes its QC review. The timeframe will vary for each state and universe depending on how long it takes the SC to receive the data and the number and complexity of QC issues it identifies. Prompt state responses to questions during the PERM cycle will reduce the time needed to draw samples.

Details Data

Submitting details information for sampled FFS claims to the SC is a critical step in the PERM process for Routine PERM states. For PERM+ states, the SC builds the details using the quarterly data submission. The RC uses the details information to request medical records and conduct MRs on sampled FFS claims. Therefore, it is vital that the states submit accurate and complete details data or, for PERM+ states, provide accurate and complete data during universe data submission that will allow the SC to create a state's details file.

Fee-For-Service Claim Details Intake Process – Routine PERM States

The SC conducts a brief “details” intake meeting (approximately one hour) with the Routine PERM states after the SC selects the first FFS sample and returns it to the state. The SC conducts these meetings via webinars and conference calls to:

- ▶ Provide an overview of the details requirements to the states

- ▶ Collect information from the state regarding the population and submission of the details data, including any challenges the state might encounter in providing the requested data
- ▶ Answer any questions the state might have on the details process

The SC uses a details intake presentation and a protocol to facilitate discussion during the Intake Meeting. Before the meeting takes place, the SC gives the state a copy of the protocol questions and asks the state to ensure the personnel best able to respond to the questions are present at the meeting. State staff involved with the collection and submission of details data should be present in the meetings. These include the state PERM lead, as well as state policy and technical staff members who will extract and compile the details data from state payment systems (e.g., MMIS), compare and validate the data against the CMS FFS Claims Details instructions for routine PERM states, and submit the data to the SC via a password-protected SFTP.

Discussion topics in the meeting presentation include:

- ▶ An overview of details submission process and requirements
- ▶ Description of crucial data fields and key pieces of information required in the details submission (e.g., beneficiary and provider information; medical service information, such as diagnosis codes, dates, and units of service)
- ▶ Review of suggested QC checks the state could conduct to verify that the details submission to the SC contains accurate information

Main topics in the Details Intake Protocol include:

- ▶ Details File Structure and Layout
 - How the state will address multiple data sources in their details submission (i.e., will the state submit one file or separate files)
 - Whether the state will submit the details in a combined header and line file or in separate header and line files
 - Whether the state plans to use the suggested field names and layouts in the details instructions or provide de-codes for the names and layouts of the fields that are used in the “state Details Crosswalk Template” provided with the sample
 - Whether the state plans to provide any user fields in the details submission
- ▶ Details Data Validation
 - What, if any, required data elements are not available and/or may not be populated for all or some claims in the details data
 - Whether the state allows for fractional units of service for certain claims in the details
 - Whether the state anticipates any issues in submitting certain fields as they were originally adjudicated and submitted in the universe (e.g., ICN, claim type, paid date, source location, payment status)

The SC compiles responses from the meeting into the Details Intake Notes and sends them to the state for review, comment, and—if necessary—correction. The SC asks the state to send any questions or revisions to the SC within one week. After the SC answers all the state’s questions, the SC finalizes the

Intake Notes and sends a copy to the state and the RC, which also participates in each state's Details Intake Meeting.

Summary of State Responsibilities during Details Intake Process

- ▶ Ensure state personnel best able to respond to Intake Protocol questions attend the intake meeting (including the state lead as well as state policy and technical staff members who will extract and compile the details data from state payment systems (e.g., MMIS), compare and validate the data against the CMS FFS Claims Details instructions for PERM-routine states, and submit the data to the SC via SFTP)
- ▶ Review and comment on Details Intake Notes within 7 days of receiving them from the SC

Fee-For-Service Claim Details Intake Process – PERM+ States

For PERM+ states, the SC creates the details based on the quarterly data submission. However, often, questions arise during this process due to state data anomalies and nuances. To ensure the SC and the RC can obtain clarifications of these issues through a discussion with the state, the SC may conduct a brief Details Intake Meeting with PERM+ states after selecting the first FFS sample to begin the details process.

The SC conducts these meetings to educate the state on the PERM+ details process and to discuss the questions and issues the SC faces while building the details data for the RC. The SC sends these questions to the state in advance to aid in preparing for the meeting. State data, policy, and technical staff; the RC; and the SC attend these meetings, which the SC conducts via webinars and conference calls.

Details Quality Control Review Process

For the Routine PERM states, submitting details information for sampled FFS claims to the SC is a critical step in the PERM process. For the PERM+ states, ensuring that the states submit all information requested in the Data Submission Instructions is critical to the success of the details process. The RC uses the details information to request medical records and conduct MR on sampled FFS claims. Therefore, in order for the RC to contact the applicable provider and review the associated medical record appropriately and efficiently, it is vital that states submit accurate and complete details data.

The SC performs a series of QC checks to ensure the state-submitted FFS details data are accurate according to PERM specifications, correctly populating all required fields in the details with non-missing, valid values. The SC conducts QC checks in stages broadly categorized as 1) data submission and 2) data validity.

Data Submission

For Routine PERM states, the SC performs data submission QC checks upon receipt of the FFS details data to verify:

- ▶ The control totals in terms of the number of lines and the total paid amount the state provides in the documentation during data submission match the control totals the SC calculates
- ▶ Information for mapping a state's field names to the standard details field names, data dictionaries, and decodes for each field (as applicable), as well as any necessary file layouts, are provided with each state data submission
- ▶ The details records match those in the universe from which the sample was drawn

- ▶ The paid date and the paid amount for all records the state sent matches the original values submitted in the universe

For both Routine PERM and PERM+ details, the SC conducts additional checks to verify:

- ▶ The details data contain all fields necessary for MRR and review
- ▶ The details data fields contain valid values or values that are listed in the data dictionary, as applicable
- ▶ The claims details include complete header and line information for each sampled claim

Data Validation

The SC performs a series of checks on both Routine PERM and PERM+ FFS details data to ensure the core variables in the details data do not contain missing values, contain valid values, are not truncated, and match the values in the sampled records. This is particularly important for the following key fields.

- ▶ ***Beneficiary ID, Name, Date of Birth, and Gender:*** Complete and accurate data for the beneficiary fields are critical for requesting medical records from providers.
- ▶ ***Billing Provider and Performing Provider Information:*** Information about name, type (when applicable), specialty (when applicable), address, phone number, and NPI (when applicable) for both billing and performing provider are necessary for contacting the correct providers.
- ▶ ***Medicaid Record Request Contact Information:*** Name, address, and phone number of the MRR contact should be included if the entity to contact to request medical records is different from the billing or performing providers.
- ▶ ***Referring Provider Information:*** Name and NPI information for referring provider, when applicable, must be included.
- ▶ ***Dates of Service:*** For line/detail paid claims, claim and line dates of service (from/to) are necessary. For header paid claims, at a minimum, header dates of service must be included.
- ▶ ***Units Paid:*** Verifying the appropriate units of service paid is one of the essential components of the MR. Data for this field are particularly important for drug claims. All paid drug records in the details data must have valid units paid that are greater than zero. If the number of units paid for drug records are not available, PERM advises the state to provide the quantity dispensed or other similar and relevant data. In addition, for data in the “units paid” field that are not whole numbers and have fractional values (e.g., 3.5), it is important to ensure the fractional values are valid and reflect the accurate number of units paid for the corresponding claim.
- ▶ ***Total Computable Amount Paid:*** SMERF should pre-populate this field for both header and line paid claims and the value in the field should be the net of any third party or patient liability, such as copayments and coinsurance.
- ▶ ***Claim Type:*** This field is the state claim-type indicator, typically identifying whether the claim is an institutional, medical, pharmacy, or crossover claim. The values for this field in the details file should match the values in the claim type field in the sampler file. However, a state data dictionary is required at the time of details submission if there are differences in claim type values between the sampler and details files.

- ▶ **Pharmacy Detail Information:** 11 digit National Drug Code (NDC), prescription number, and drug order date are mandatory for MR of drug claims.

- ▶ **Diagnosis Code:** Primary diagnosis code is mandatory for all claims (when used for payment determination) except for drug and dental claims. State must include all secondary diagnosis codes, as available.

- ▶ **Procedure, Revenue, and Diagnosis-Related Group (DRG) Codes:** ICD-9/10 procedure, DRG, revenue, and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes for header-level or line-level claims must be included in the details data as applicable.

In addition to performing these broad categories of quality checks, the SC performs a range of analyses on the PERM details submission to ensure the data align with the notes from the Claims Intake and Details Intake Meetings and documentation sent by the state.

During the course of the data review and through the RC's review, it is possible that the SC will seek clarification about the data from the state. Many times, the RC will need to validate information in the sampled claim line or will need additional information to complete the reviews. When this occurs, the RC requests the specific information it needs from the SC and the SC reviews the universe and details data for the required information. Next, the SC sends an email to the state PERM contact asking for the required information. After the state submits the information, the SC sends the RC a final response resolving the issue.

Reviews

The RC reviews sampled Medicaid and CHIP claims and payments for correct payment according to federal regulations, state policies, and procedural guidelines.

State Policy Collection Process

The RC is responsible for acquiring federal regulations and Medicaid and CHIP policies for each state. The RC is also responsible for maintaining a database with a complete set of policies governing each selected state's respective Medicaid program and CHIP. These policies govern the 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

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

The RC communicates with each state at the beginning of each PERM review cycle. The RC begins the policy collection process by researching state website(s) for all available state policy documents that contain Medicaid and/or CHIP policies relevant to the DP review and/or MR of claims. The RC downloads these policies and compiles a Master Policy List of all relevant policies for each state. After completion of each state's Master Policy List, the RC sends it to the state for confirmation and approval. The state may provide additional resources that frequently are not publicly available, including system navigational guides, sample managed care contracts, fee schedules, etc. Once the state approves the Master Policy List, the RC categorizes and stores all of the state's policies, federal regulations and other documentation in SMERF under the Policy Tab to ensure that its reviewers have ready access to that guidance as they conduct reviews. The RC continues to monitor and collect state policies throughout the measurement year, and validates the list with the state as appropriate.

State Responsibility for Policy Collection

- ▶ Provide documents requested for DP reviews that are not publically available on the state's websites
- ▶ Provide final approved policy questionnaire to RC
- ▶ Provide final approval of Master Policy List

Data Processing Reviews

The RC conducts DP reviews on each sampled FFS and managed care payment to validate the state processed the claim correctly based on information found in the state's claim processing system and other supporting documentation maintained by the state. A DP error is a payment error resulting in an overpayment or underpayment that the state's MMIS or other payment systems could have prevented. Claims not processed through a state's MMIS are subject to validation through a paper audit trail, state summary or other proof of payment.

The RC conducts DP reviews either on-site or remotely for both FFS and managed care claims. When the state processes CHIP claims at separate locations independent of the state's MMIS, the RC coordinates remote system access or visits to those locations.

The on-site review consists of four-to-six weeks of reviews based on the state's sample size. The RC's reviewers and state representatives participate in an exit conference at the end of each weekly visit. If the state prefers to have the DP review team on-site for two consecutive weeks, advanced planning may allow the RC to accommodate such requests.

The RC will request DP manuals, systems navigational tools, and pricing guides before and during the Introductory Webinar and orientation meeting if not available on the state's websites.

To complete DP reviews, the reviewers may need access to screens containing information on NDCs and/or revenue/procedure codes, payment rates and pricing schedules for all types of claims. Reviewers may also need to access rates for older dates of service. If the state makes retroactive rate adjustments, it will be necessary for the RC to access the rates that were in effect for the date of service on the claim under review.

DP reviewers may require information about how the state calculates each type of payment. 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 reviewers can accurately determine pricing. The reviewers may need access to other claims in the system in order to check for duplicates. Since the reviews include confirming the aid categories and date spans for the beneficiaries, the state must provide the reviewers with direct access to the eligibility system. If direct access to the eligibility system is unavailable, the state must provide the reviewers with a report or screen prints from the source system when the reviews start. The state must make these arrangements with the lead reviewer before the review start date. The reviewers will use their independent access to the Office of the Inspector General List of Excluded Individuals/Entities (OIG/LEIE) to verify whether any provider related to the claim (billing, attending/rendering, or ordering/referring/prescribing) was excluded from Medicaid programs on the claim paid date. 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 reviewers may need access to tables that explain codes used in the system if the system's "help" menu does not contain this information.

Data Processing Orientation/Introductory Webinar

The RC schedules a DP Orientation and Introductory Webinar with each state before the PERM DP reviews commence. The RC holds this Orientation Meeting/Introductory Webinar early in the cycle to begin facilitating DP reviewer access to state systems. On-site orientation meetings may be necessary when state PERM personnel changes occur, when the state implements a new MMIS system, or when the state requests an on-site meeting.

Orientation Meetings/Introductory Webinars can last one-to-two hours depending on whether the RC needs to conduct systems reviews. States with multiple systems of record may need more time for the

orientation. In addition, states that have a separate fiscal agent or system for their CHIP may need additional time for the orientation.

At a minimum, the following state personnel should attend these DP Orientation Meetings/Introductory Webinars:

- ▶ PERM coordinator
- ▶ Claims manager(s)
- ▶ Individuals involved in determining whether to file a DR request or Appeal for errors cited
- ▶ Individuals who pulled and sent data for the universe
- ▶ The person or people familiar with the process for obtaining access to the eligibility system(s)
- ▶ The waiver program representative
- ▶ The CHIP representative
- ▶ Representative for any other special programs for your state

Agenda items for the Orientation/Introductory Webinars:

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

State PERM Coordinator Responsibility for DP Orientation/Introductory Webinar:

- ▶ Respond to the DP orientation/Introductory Webinar invitation timely and help determine a date and venue for the meeting
- ▶ Invite all appropriate people to the meeting
- ▶ If the meeting is on-site, schedule the conference room and projector in advance
- ▶ Make copies of all handouts or send them to participants in advance

- ▶ Complete and return the systems questionnaire(s) prior to the meeting

Prior to Starting DP Review:

- ▶ State supplies systems access forms, confidentiality forms, Data Use Agreements (DUAs) or other required documents for the assigned DP reviewers or RC to complete. The documents required vary from state-to-state depending on each state's systems security requirements.
- ▶ State determines a location for the review team and ensures that state computers are set up and ready for the review team when they arrive. DP reviewers use state computers to access the state's systems and to create or print screen prints as needed during the review.
- ▶ For remote reviews, the RC schedules a conference call between the state's IT personnel and the RC's IT personnel to facilitate reviewer access to the state's MMIS.
- ▶ State PERM coordinator alerts Subject Matter Experts (SMEs) to be available the week(s) the reviewers are on-site to answer questions as needed.
- ▶ State alerts the security desk to expect the on-site reviewers and arrange for visitor passes if required.
- ▶ State PERM coordinator and the lead DP reviewer work together to ensure all necessary arrangements are in place before the reviews start.
- ▶ Before the reviews start, the RC creates desk aids (from materials gathered during orientation and from state websites) for SMERF that all DP reviewers assigned to the state review can access.
- ▶ Approximately six weeks before a scheduled on-site review, the RC completes travel arrangements for all reviewers traveling to an on-site review. Reviewers generally travel on Sunday, and work Monday through Friday. The RC's lead DP reviewer and state PERM personnel establish mutually agreeable work hours for the RC's DP reviewers during the review week.

State Responsibility Prior to Starting DP Reviews:

- ▶ Provide the lead DP reviewer with all information requested at the DP orientation/introductory webinar at least two weeks before reviews begin.
- ▶ Reserve an appropriate room for reviewers with space for two computers per reviewer and printing capability from the state-supplied computer. (Note: the RC supplies computer for accessing SMERF; state provides computer for accessing MMIS.)
- ▶ Make sure all computers are in place prior to the day the reviews start.
- ▶ Collect and submit all forms required to provide the RC's reviewers with system access, and create login accounts and passwords for the reviewers in advance of the on-site visit so the reviewers can start their reviews as soon as they arrive on the first day. This applies to all systems the reviewers will need to access, including MMIS, eligibility (if direct access is selected), and imaging or other systems such as dental or pharmacy if claims are not in MMIS.
- ▶ Notify building security that the reviewers will need access for the dates they are on-site and arrange for visitor or audit passes based on the state's requirements. Also, advise the lead DP reviewer about parking requirements for the building.

- ▶ Submit the signed state DP Visit Checklist to the RC's lead reviewer to confirm the state's readiness to begin DP reviews.
- ▶ ***For remote reviews only:*** Make sure state and RC IT staff have worked together to establish systems access in time to start reviews as planned, and establish a help desk contact for access and password issues.

On-site Data Processing Reviews:

For on-site reviews, the reviewers will usually arrive at 8:00 a.m. (or another agreed-upon start time). Reviewers will normally work until 4:30 p.m. with a half-hour break for lunch; however, the lead reviewer for each state will work with the PERM coordinator to establish a work schedule that is convenient for all involved in the PERM review process. The review team is flexible with work hours but needs to be able to conduct reviews for a full 8 hours per day, Monday through Friday.

Throughout the week, the lead reviewer will filter questions about specific claims review issues to the designated state PERM contact. The lead reviewer will update these pending lists at least daily during the review, adding new issues and dropping resolved issues as warranted. The state PERM coordinator should work with the most recent list to avoid duplication of work. Ideally, state PERM personnel will answer all questions on pending issues while the review team is on-site. It is important that all persons providing answers to the questions be available during the review week and understand the importance of responding to the questions as quickly as possible, because doing so will reduce the number of pending issues as one answer often applies to many reviews.

Usually on Friday of each review week, the RC's lead reviewer and interested state personnel participate in an exit conference. During the exit conference, the lead reviewer distributes a report covering the number of reviews completed during the week and the number of issues still pending at the end of the week. The report also itemizes any errors discovered. In addition, the lead reviewer distributes a final pending list and discusses it with conference participants. The lead reviewer and state PERM Coordinator also make plans for return visits as needed during this meeting.

State Responsibility during On-site Reviews:

- ▶ Make sure SMEs are available to answer questions during the review week
- ▶ Review pending list daily and follow-up with SMEs to get needed answers back to the review team while they are on-site
- ▶ Work with the lead reviewer to schedule an exit conference at end of the week
- ▶ Coordinate with IT to resolve any access issues the review team encounters
- ▶ After the review week, the state will be given two weeks to provide any supporting documentation and answer any questions outstanding from the on-site review; additional time can be allowed if a SME is unavailable (usually two weeks).
- ▶ Review and monitor the Pending Report (P1 report) in SMERF. This report will be accessible on the state's portal and exportable to Excel to allow states to sort data as needed and to track all pending requests to completion.
- ▶ Follow up on P1 notifications (system-generated reminder emails) that the RC sends to the state weekly to report all pending requests that are past due. State PERM Coordinators must monitor all

pending requests to ensure the state promptly submits requested information to the RC in accordance with the RC's instructions for providers' submission of medical records to complete all pending reviews in a timely manner.

Remote Data Processing (DP) reviews:

States that opt to have the RC conduct the PERM DP reviews remotely will coordinate with the RC's lead reviewer to have all access and security forms completed before the date reviews start. The lead reviewer sends pending lists to the PERM Coordinator every couple of weeks depending on work progress, and gives the PERM Coordinator a deadline (usually two weeks) to respond to any pending issues. The lead reviewer schedules two or three exit conferences during remote reviews to update the state on review progress, troubleshoot unresolved issues, and discuss any newly identified pending errors.

State Responsibility during Remote Reviews:

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

Advanced Notification of Potential Data Processing Errors

During the DP review, the lead reviewer lets the state liaison know about any errors identified during the review week (usually confirmed at the exit conference). For remote reviews, the lead reviewer will discuss potential errors with the state liaison via email correspondence. Note: Even if the lead reviewer advises that the RC identified an error during the on-site review, it is important to remember that all errors—MR or DP—must undergo two full reviews by two different reviewers before the RC considers the errors final. Therefore, although the state may learn of an error during an on-site visit, it may take up to another month for the second level review of that error to occur and for the error to appear on a SUD report. The RC sends the state advanced notification of the error finding the night after it completes the second level review, and it will post the error on the next SUD report. The RC generates SUD reports on the 15th and 30th days of each month during the review phase of the Cycle.

Medical Records Requests

The RC is responsible for requesting all medical record documentation associated with the randomly selected Medicaid and CHIP FFS claims that will undergo MR. The RC submits requests directly to the provider's medical record location as verified by the provider.

Medical Record Request Orientation

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

State PERM Coordinator Responsibility for RC Educational Webinars:

- ▶ Respond to the webinar invitation timely
- ▶ Reserve a conference room and equipment for webinar participants

- ▶ Invite all appropriate people to the meeting
- ▶ Make copies of all handouts or send them to participants in advance

State Responsibility Prior to Starting Medical Record Requests

- ▶ Provide completed MRR questionnaire to RC
- ▶ Review and validate MMIS provider contact information for claims
- ▶ Identify medical documentation management processes followed by fiscal agents and sister agencies
- ▶ Identify special documentation processes or contact information for corporate contacts or multi-hospital systems
- ▶ Provide current contact information for state representatives

Records Requests

Initial Request for Records

Before sending the Initial Request for Records, the RC contacts the provider and introduces the PERM program. The RC also attempts to verify the claim and the provider's contact information, and to learn whether the provider would like to receive the request by fax or by mail. After verifying the provider's contact information, the RC sends the provider an official letter requesting documentation. Providers must submit the medical record documentation within 75 days from the date of the letter. The RC will send up to four follow-up letters and make up to four phone calls to each provider during this 75-day window, as needed, to secure the provider's compliance with open documentation requests. If the provider fails to produce the requested documentation by the 75th day, the RC sends a Non-Response to Request for Records letter via certified mail to the provider and gives a copy to the state representative.

Additional Documentation Requests for Incomplete Information

When documentation submitted by providers is incomplete, the RC calls the providers and sends them a Request for Additional Documentation in an effort to secure the additional documents needed. Providers have 14 calendar days to submit additional documentation. The RC will make 7-day reminder calls and send corresponding letters to the providers if it does not receive these additional documents. The RC will send Non-Response to Request for Additional Documentation letters to providers via certified mail and copies to the state representative if it does not receive the remaining documentation by the due date. The RC sends out Receipt of Incomplete Information letters to providers if the additional documentation it receives by the due date is still insufficient.

Resubmission Documentation Requests

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

- ▶ Illegible copies of the medical record documents
- ▶ Incorrect dates of service submitted
- ▶ Medical record documentation submitted for the wrong patient
- ▶ No medical record documentation submitted with PERM Cover Sheet
- ▶ No beneficiary name and date of birth on medical record documents

- ▶ Incomplete fax received (e.g., the RC receives only 4 pages of a 30-page submission)

Processing Late Documentation

The RC will accept documentation until the cycle cutoff date. This means that providers may still submit new documentation for review until the end of the cycle even if the RC has cited the claim as an error because the provider failed to respond to its requests for records, or submitted only incomplete or insufficient documentation, even if the state's DR/Appeals timeframes have expired. State assistance in collecting these late records is essential in reducing documentation error findings. State follow-up with providers should continue even after the 75-day and 14-day due dates have passed.

State Assistance with Contact Information

If the RC is unable to verify the correct provider information from a state's claim file or outside research, the RC will contact the state's Medicaid/CHIP PERM Coordinator for assistance.

State Assistance with Obtaining Medical Records from Providers

The state must work closely with the RC to obtain medical records from providers. The RC provides claim information and tracks provider responses to requests via the SMERF system. The states use the SMERF system to track RC MRRs and to monitor provider responsiveness to those requests. The RC notifies states via email the day after it sends MRRs or follow-up letters to providers. The RC Records Manager collaborates and coordinates MRRs with states to ensure timely processing of MRRs. Based on the information from SMERF, email notices, and communication with the RC Records Manager, the states must closely engage providers to ensure the RC receives all requested medical records before the 75-day due date or cycle cutoff date, at the very latest.

State Best Practices for Obtaining Medical Records from Providers

- ▶ Send letters to each sampled provider about the PERM program and medical records requests processes before MRRs begin
- ▶ Provide RC with updated contact information on providers
- ▶ Identify a contact person for corporate medical organizations, school systems, and state fiscal agencies
- ▶ Develop Integrity Teams to help locate and contact providers
- ▶ Review and edit contact information in the state MMIS
- ▶ Monitor the status of medical records requests via the SMERF system

State Responsibility during MRR Process

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

Medical Review

Before conducting MRs, the RC conducts educational webinars to introduce the state to the policy collection and MR processes for PERM. The RC distributes the state's draft policy questionnaire and

draft Master Policy List, both of which contain the policy research results from the state's website(s). The RC requests verification of the completed policy questionnaire to ensure that previously located public policies and regulations are sufficiently comprehensive to conduct MRs. This allows the state to clarify policies, if needed, and to ask questions about the MR process. The RC conducts educational webinars for states as part of this process.

At a minimum, the following state personnel should attend these meetings/webinars:

- ▶ PERM Coordinator
- ▶ SMEs on relevant topics
- ▶ Staff members who help the RC obtain state policies
- ▶ Staff members who contact providers to obtain medical records
- ▶ Staff members involved in filing DR requests and/or Appeals
- ▶ Other staff members who participate in the PERM review process

The RC conducts MR on all sampled FFS claims, with the exception of Medicare Part A and Part B premiums, Medicare crossover claims, primary care case management payments, aggregate payments, denied claims, and zero-paid claims. MR may be required for denied claims if the state denied the claim for medical necessity or other reason verifiable only through review of the medical record. The MR is exclusive of the DP review. States can access or track MR findings in SMERF.

An MR error is a payment error that is determined from a review of the medical documentation submitted, the relevant state policies and federal regulations, and a comparison with the information presented on the claim. The RC performs MRs to validate whether the state paid the claim correctly according to the documentation submitted, assessing each claim to determine the following:

- ▶ Adherence to the state's guidelines and policies and federal regulations related to the service type
- ▶ Completeness of medical record documentation to substantiate the claim
- ▶ Medical necessity of the service provided
- ▶ Validation that the service was provided as ordered and billed
- ▶ Claim was correctly coded according to coding guidelines

State Responsibility Prior to Starting Medical Reviews

- ▶ Provide final approved policy questionnaire to RC
- ▶ Provide final approval of Master Policy List

Tracking Errors and Responding to Findings

The SMERF system is a web-based application used to track and report review findings and MRRs for the PERM program. The CMS ROs, the SC, the RC, and the states all interact with the SMERF system. Each entity that interacts with the SMERF system has a web interface module designed for its specific purpose. The system is comprehensive and capable of assisting the PERM staff with access to MRRs, improper

payment rates, DP Errors, MR Errors, SUD reports, dispute error findings, year-to-date Errors, and recoveries reports.

Tracking Errors

The RC officially reports errors identified through DP review or MR to the state through SUD reports it generates on the 15th and 30th days of each month. The generation of a SUD report starts the state's timeframe to dispute errors identified in that SUD report.

However, the state receives advance notification of each error, which allows it to start investigating potential errors even before the RC publishes the SUD report. When the RC identifies an error through MR or DP review, the SMERF system sends an automated email message to the primary and secondary state contacts, providing advance notice of the error. The SMERF website also lists the error under the advance notice of DP errors menu or MR errors menu. Errors will remain on the advanced notice menus until the RC issues a new SUD Report.

SUD Reports contain results of DP and MR reviews conducted since the RC last generated a SUD Report. Y-T-D SUD reports contain results of DP and MR reviews conducted since the beginning of the measurement period.

On the SUD Reports, red-lettered error codes reflect cited errors, while green lettered codes reflect observed deficiencies. All DP errors begin with the letters DP and all MR errors begin with the letters MR. The RC classifies deficiencies as either Data Processing Technical Deficiencies (DTD) or Medical Technical Deficiencies (MTD). C-1 represents a review with a finding of correct payment. The date of the SUD report starts the filing timeline for a DR request. There is a one-week cutoff prior to the issuance of the SUD Report, so errors completed by the RC less than 7 days before the issuance date usually will not be available until the next SUD report.

Requesting Difference Resolution

Once the RC posts an error on a SUD report, the state's opportunity to file a DR request begins. States must request DR within 20 business days after the RC publishes the SUD report.

The state should file a DR in the following circumstances:

- ▶ The state disagrees that an error/deficiency occurred.
- ▶ The state disagrees with the amount of the underpayment or overpayment (remember that MR partial errors will initially be cited for 100% of the payment amount). The state must file a DR request and provide written evidence, such as fee schedules, screen prints, etc., that substantiate how the state determined the correct pricing amount to reduce the error amount to the difference between what the state paid and what the state should have paid.
- ▶ The state has subsequently acquired additional documentation from the provider to submit to the RC to attempt to overturn a Document(s) Absent from Record (MR2) error. Please note the state is not required to file a DR to submit additional documentation obtained after an MR2 error finding. The state can submit additional information to the RC (under the late documentation policy) up until the end of the cycle and the claim will automatically reopen for another MR.

The state has 20 business days to file a DR request and supply documentation to support its position, or as evidence of re-pricing needed for partial errors.

How to File a DR Request

Once the state decides to file a DR request, the state liaison must access the SMERF website and enter the DR request by using the DR drop down menu down (under the Errors Tab on the home page). Click on cases available for DR to find and select the review the state wishes to dispute. Please refer to the SMERF State User Guide for detailed instructions along with screen prints of the process in SMERF. **Note: Please do not enter any Protected Health Information (PHI) into comments in SMERF!** Instead, indicate in the comments box if the state has submitted supporting documentation to the RC via fax, SFTP upload, regular mail, secure email, or encrypted email. The SMERF State User Guide is available on the SMERF homepage under the Tools Menu and via a link on the home page.

Once the state has filed the DR request in SMERF, it is important to send supporting documentation, if needed, to the RC on the same day. To send supporting documentation to the RC, print out the cover sheet from SMERF so the documentation can be easily associated with the error the state is disputing. Submit records to the RC via the United States Postal Service, a toll free fax number, CD, or electronic submission of Medical Documentation (esMD). For more information about esMD, see <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html> New for FY 2017, providers can also send documents in encrypted secure emails to Records@permrc.com or send an encrypted file to Records@permrc.com and contact PERM Customer Service Representatives at 301-987-1100 to provide the file encryption password.

The RC will send an automated email notification from SMERF to the state to confirm receipt of the DR request. It is important to create a cover sheet for each PERM review and submit the records independently from other submissions. However, if the same documentation applies to multiple PERM IDs, the state can list each PERM ID on the cover sheet to file the documentation with each applicable PERM ID. If the state submits supporting documentation by secure email or SFTP, it should include the PERM ID in the name of the electronic file it submits.

Responding to a Difference Resolution Request

The RC will respond to the DR request within 15 business days. Once the RC has determined whether to reverse, modify, or uphold the original review decision, the RC will record the decision in SMERF and notify the state by email so the state will know to access SMERF to view the results of the DR. If the state is satisfied with the RC's 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 10 business days after notification of the DR decision.

Re-pricing Partial Medical Review Errors

During MR conducted for the PERM program, the RC reviews sampled claims' medical records for medical necessity, coding validation and accuracy of payment. In some cases, the RC may make an error finding (e.g., procedure coding error, number of units error) that initially would be reported as 100% error, but should only result in a portion of the payment being in error (partial error). The state is required to re-price partial errors using the DR process by submitting written re-pricing evidence so the RC can calculate the correct error amount.

Types of errors that may partially affect payment include:

- ▶ MR 3 - Procedure code error
- ▶ MR 4 - Diagnosis code error
- ▶ MR 5 - Unbundling

- ▶ MR 6 - Incorrect number of units billed
- ▶ MR 10 - Administrative/Other

In addition to the above error codes assigned, the SMERF system identifies partial errors that require re-pricing through the DR process under the list of cases available for DR. The title of the last column on the list is “needs to be re-priced” and the column will be marked with a “Y” (for yes) to indicate this is a partial error finding requiring the state to file a DR request to correct the amount in error.

For partial MR errors, the state can review the assigned error amounts to determine if it should seek re-pricing at the DR stage of review. State research of the correct payment amount can begin when the state receives the advanced error notification to allow time to gather evidence for re-pricing and to prepare for the DR opportunity.

When the state supplies the re-priced amount, the RC calculates the amount in error by taking the amount the state paid and subtracting the amount 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 a re-priced amount, then the error will be 100 percent of the paid amount for that sampling unit. If the state does not provide supporting documentation during DR or if the state does not request DR, the full amount of the claim will remain as the error amount.

Filing an Appeal to CMS

If the state still disputes the RC’s decision after the DR process, it may appeal to CMS. The state has ten business days from the date of the RC’s DR decision to file the Appeal. The RC will give CMS all documentation previously submitted including the medical record. The state may submit additional documentation with its Appeal that it did not previously submit to the RC. To submit Appeal requests, the state follows the same process it used to submit a DR request in SMERF, but enters the request via the Appeals menu.

The state, the RC, and CMS receive an email confirmation once the state files an Appeal. CMS convenes a panel to review Appeals and usually reaches a decision within 45 days. Once CMS issues a decision, the state will receive an email notice that the Appeal decision is available for review in SMERF.

The CMS Appeal decision is not reversible and marks the final step in the dispute process.

End of Cycle Activities

The PERM cycle normally ends the summer after the FY under review (i.e., the FY 2017 cycle will end in the summer of 2018). States have many important responsibilities at the end of a PERM cycle.

Cutoff Date

CMS sets a cycle cutoff date for each cycle to ensure the PERM program reports improper payment rates timely. For the RC to review documentation or respond to a DR request before reporting, etc., the state must submit its request before the cycle cutoff date. The PERM program calculates improper payment rates based solely upon information received from states/providers before the cycle cutoff date. This is an external date for CMS to receive information, not for completing reviews. The RC will review the documentation it receives by the cycle cutoff date, and the RC will complete any DRs requested before the cutoff date for improper payment rate calculation.

Typically, the cycle cutoff date is the second July 15 of a measurement cycle. However, the cycle manager may push back the cycle cutoff date depending on the progress of the cycle and, if so, will notify the states of that decision through emails and cycle calls.

Since CMS accepts late documentation, it is essential that states continue to follow up with providers to try to obtain the necessary documentation before the cycle cutoff. If as long as a provider submits documentation by the cycle cutoff, the RC will review it even if the provider's 75 day or 14-day timeframe may have expired. Likewise, if the RC cites a claim as an error due to lack of documentation and the provider or state submits supporting documentation, before the cycle cutoff date, the RC will review that documentation even if the DR and Appeals deadlines have passed.

CMS encourages states to use the "Estimated Impact on Error Rate" report available on the state portal in SMERF to help focus any last-minute outreach efforts for errors that will have the biggest impact on the state improper payment rate. CMS will also make calls to providers in an attempt to help rectify No Documentation (MR1) and Document(s) Absent from Record (MR2) errors that have the biggest impact on the national rate and will coordinate with your state during this process. CMS also accepts late documentation until the cycle cutoff date for DP reviews classified as Pending state documentation (P1) and/or as Administrative/Other (DP12) errors documentation. DR requests and Appeals received after the cycle cutoff date are not included in national improper payment rate calculations. Therefore, CMS encourages states to submit a DR request before the cutoff date even if its 20-day timeframe does not expire until after the cycle cutoff date rather than wait the full 20 days. These instances, however, may be eligible for continued processing.

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: (1) The RC received medical records for a claim after the cycle cutoff date but within 75 days of the initial request for medical records or within 14 days of requests for additional documentation; or (2) The RC cited an error before the cycle cutoff date but the state's allowable timeframe to request DR or CMS Appeal extended beyond the cutoff date.

Under such circumstances, those claims enter continued processing, and CMS will recalculate a state's improper payment rate based on the continued processing results. Consequently, it is important that states continue to respond to errors even after the cycle cutoff has passed.

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 cited as an error was correctly paid (e.g., successful provider Appeal results, claim adjusted after PERM 60-day window), it can work with the CMS PERM Recoveries Personnel financial contact to determine what adjustment to the expenditure reports is required for recovery purposes.

Recoveries

The state must return the federal share of Medicaid and CHIP FFS and managed care overpayments the PERM program identifies on a claim-by-claim basis.

Requirements

The state must return the federal share within one year from the date the RC generates the End Of Cycle (EOC) PERM FEFR report. After the RC completes all continued processing reviews, the EOC FEFR contains a comprehensive list of all overpayment errors.

The state returns the federal share of identified FFS and managed care overpayments through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) on the CMS-64 and/or CMS-21 expenditure reports. The state reports PERM recoveries for Medicaid that the state collects or voluntarily returns to CMS during the one-year period on Line 9F of the CMS-64. The state should report PERM recoveries that the state does not collect from the provider within the one-year period on Line 10D of the CMS-6s. The state reports PERM recoveries for CHIP on Line 5 of the CMS-21.

Each state should involve their financial staff for tracking PERM recoveries/overpayments. Throughout the recoveries process, the state should work with the CMS PERM Recoveries lead that will coordinate with the state's CMS RO financial contact.

Reports

End of Cycle Final Errors for Recovery (FEFR) Report

The RC posts each state's EOC FEFR report on SMERF after it completes continued processing and finalizes all findings for the state for the cycle. The EOC 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 for the cycle, and the RC officially notifies states' Medicaid and CHIP Directors via email when it posts the EOC FEFR report on SMERF.

Exceptions

There are some exceptions to the requirement that states must return the federal share of an overpayment within one year of identification:

- I. ***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.
- II. ***The state adjusts the claim to the correct amount*** – The PERM program reviews claims paid or denied in each quarter of the federal FY, 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 these instances, the state is not required to return the federal share. The state should notify the PERM Recovery Lead and provide documentation (e.g. screen shots, etc.) of the adjustment.
- III. ***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 Appeals process, the state should submit documentation to the PERM State Liaison and CMS reviews the documentation to determine whether the federal share needs to be returned.
- IV. ***Provider 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. **As a reminder, please do not send Personally Identifiable Information (PII) nor PHI information through the email.** CMS' PERM Appeals panel reviews the documentation to determine if it demonstrates the state correctly paid the claim.

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.

Post-Cycle Documentation

States participate in the PERM program on a three-year cycle. This means that once data collection is complete for one PERM cycle, it will be more than two years until data collection starts for the next PERM cycle (e.g., for FY 2014 the last data submission was due on October 15, 2014 and the first data submission for FY 2017 was January 15, 2017). Post-cycle documentation is a critical part of the PERM cycle. States can save themselves many hours of work in future PERM cycles by documenting key staff, data sources, programs, and technical issues at the end of the current cycle. The state should document the following items at the end of a PERM cycle:

- ▶ ***Key staff:*** A list of the names and positions of all state staff, fiscal agent staff, and staff from outside vendors who worked on PERM. Knowing who worked on PERM in the past, their respective roles in PERM, and their level of involvement in the measurement can help states retain knowledge about PERM and reduce the impact of any staff changes on upcoming PERM cycles.
- ▶ ***Data sources used in PERM:*** Many states process some of their claims matched by Medicaid (Title XIX) or CHIP (Title XXI) funds in claims processing subsystems outside of the main MMIS. States submit these claims in the PERM universes along with claims data from their main MMIS. States can easily identify these off-MMIS claims data sources in the upcoming PERM cycle by preparing a list at the end of their current PERM cycle.
- ▶ ***Programs and payments excluded from PERM:*** Make a list of programs and payments in Medicaid and CHIP that CMS and the contractors considered for PERM review in the current cycle but decided to exclude. The state should also briefly describe why PERM did not review the program or payment. The PERM program constantly strives to improve its data review methods, and changes in PERM methodology could cause a previously excluded program or payment to be included in PERM in future cycles.
- ▶ ***Computer programs used for PERM:*** The file specifications for PERM universes, PERM+ data submissions, and PERM sample details will be relatively similar from cycle-to-cycle. Once a state develops programs to collect PERM data, the state will want to use the same programs, with modifications, in the upcoming PERM cycle unless system changes occur between cycles. Therefore, the state needs to identify and document all computer programs used to collect PERM data and create PERM universes, details, and other data submissions.

Technical issues: It is possible the PERM program could reveal policy and data issues during the course of the PERM cycle that could continue complicating PERM data submission in subsequent cycles. These issues do not necessarily imply any problems with a state's MMIS or other claims processing systems, but are a result of how PERM rules and regulations interact with state claims

data. For example, PERM rules require the inclusion of Medicaid managed care stop-loss payments in the Medicaid FFS universe. A state may actually store the stop-loss payment records in its Medicaid managed care payment subsystem. The state would have a documented process to address the technical issue of how to move the stop-loss payment into the PERM FFS universe. The state will save time in the upcoming PERM cycle by documenting solutions it developed for such long-term cycle issues.

1. Improper Payment Rate Reporting

Overview

Overview of Improper Payment Rate Calculations

The PERM SC bases all improper payment rate calculations for the Medicaid and CHIP programs on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. The SC calculates improper payment rates for Medicaid and CHIP separately and does not combine those rates. The PERM SC calculates improper payment rates once the RC finalizes the cycle findings. This typically occurs in the late summer/early fall of the year following the measurement period.

Projected Dollars in Error for State Improper Payment Rates

To calculate the improper payment rates, the SC first calculates both estimated improper payments and estimated total payments using sample improper payments and sample total payments. PERM follows a stratified sampling design for each state. For the FFS and managed care universes, the strata are dollar-weighted (i.e., each stratum has an equal value of dollars). PERM randomly selects a predetermined number of units within each stratum and the SC assigns each sampled unit a sampling weight based on the probability it will sample that unit from that stratum. The SC multiplies the sample improper payment and paid amount by the sampling weight associated with each of the sampled units to calculate the “projected” improper payment/paid amount for that sampled unit.

Calculation of State Improper Payment Rates

For each state, three dollar-weighted improper payment rates are calculated: FFS, managed care, and overall. The SC calculates improper payment rates for FFS and managed care separately by adding the total projected improper payment/paid amount for each component within each state and then calculating the percentage of improper payment to paid amount. Then, the SC combines component improper payment rates to form the overall state improper payment rate.

Projected Dollars in Error for National Improper Payment Rates

Like the state improper payment rates, there are three dollar-weighted improper payment rates calculated nationally: FFS, managed care, and overall. Since PERM samples 17 states each year, the SC calculates the national improper payment rate by pooling the three most recent years’ data. For each state component, the SC multiplies sample improper payment amount for each state by their respective sampling weights to calculate the state improper payment rate. The SC calculates the national improper payment rate for a component (i.e., FFS, managed care, overall) as a weighted estimate of the 51 state rates where the weights for each state is the share of state payment for the component.

As noted, the SC calculates no state-specific PERM eligibility error at this time. However, the SC includes an estimated eligibility component improper payment rate in the national overall PERM improper payment rate. CMS has frozen the national eligibility improper payment rate at the rate from

the most recently completed PERM cycle, through the FY 2017 cycle, to develop the national overall PERM improper payment rate.

Calculation of National Improper Payment Rates

The SC calculates national dollar-weighted improper payment rates for FFS and managed care separately by adding the national projected improper payment/paid amount in each component and then calculating the percentage of improper payment to paid amount. The national rolling improper payment rate includes the latest projected improper payments and projected total dollars from 50 states and the District of Columbia so that each state is represented in the national-level statistics. The SC calculates the overall national improper payment rate by combining the frozen national eligibility improper payment rate with the national FFS and managed care component rates.

Calculation of Cycle Improper Payment Rates

The SC calculates the cycle rate using a similar method to the one used to calculate the national improper payment rate. However, instead of pooling the data from all 51 states, the SC only uses data from the 17 states sampled in a given year. The SC calculates the improper payment rates for FFS and managed care separately. The SC combines the component improper payment rates to form the overall cycle improper payment rate. Eligibility is not included in the official cycle improper payment rate calculation for years when the eligibility review is frozen.

Error Rate Notifications & Cycle Summary Reports

States receive official notification of their results through the Error Rate Notifications and Cycle Summary Reports. CMS also posts these reports in SMERF, typically releasing them around November 15 the year after the measurement period (i.e. FY 2017 improper payment rate reports will be released November 2018). Each state receives two reports—one for Medicaid, and the other for CHIP.

Improper Payment Rate Recalculations

If an error is overturned or changed during continued processing, CMS will issue a recalculated improper payment rate once continued processing is complete. The state will receive a recalculated Error Rate Notification document. The SC calculates the new projected sample size for the next PERM cycle based on the new improper payment rates. The RC also posts these reports on SMERF. However, the SC will base the state's target improper payment rates for the next cycle on the original component improper payment rates, as targets are only used for guidance.

The SC factors the state's improper payment rate into the official 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.

2. Corrective Action Process

Following each measurement cycle, each state included in the measurement must complete and submit a CAP based on the errors found during the PERM process. CMS provides guidance to state contacts on the CAP process upon publishing PERM improper payment rates and throughout CAP development until the CAP's specified due date, which is 90 calendar days after the state's improper payment rates are posted in SMERF.

The CAP process involves analyzing findings from PERM, identifying root causes of errors, and developing corrective actions designed to reduce major error causes, trends in errors, or other vulnerabilities to reduce improper payments. The state's new CAP should also include an evaluation of its previous CAP. Through the CAP process, States can take administrative actions to reduce errors that cause improper Medicaid and CHIP payments.

CAP Process

PERM State Liaison Team

The role of the PERM State Liaison Team in regard to the CAP process is to support the corrective action phase of the PERM program by analyzing improper payment rate data to help reduce improper payments in Medicaid and CHIP through corrective actions taken at the federal and state levels. The team maintains partnerships with the states to foster collaboration and gain state participation in establishing their corrective actions. The team's primary responsibilities include working with the states to assist them in the development, timely submission, implementation, and evaluation of their CAPs.

The PERM State Liaison Team invites the CMS ROs, the Center for Program Integrity (CPI), and the CMS PERM contractors to attend all calls it schedules (e.g., kick-off calls, state cycle summary discussion calls, CAP evaluation calls, and other calls that are necessary and reasonable).

CAP Kick-off Call

In September, after the measurement review ends and before CMS publishes the states' improper payment rates in SMERF and in the AFR, the PERM State Liaison Team holds an initial "CAP kick-off call" with all states in the measurement to discuss the corrective action process. Prior to the call, the team forwards several documents to the state for review, including a PowerPoint presentation explaining the CAP process, the October 2007 State Health Official (SHO) letter, CAP instructions, and a "kick-off call" agenda. The states are encouraged to invite whomever they feel needs to attend this kick-off call.

Individual State Calls

The next contact with the states is in November after CMS releases the official improper payment rate and posts the state's improper payment rate in SMERF. The PERM State Liaison Team makes individual calls to the 17 states that participated in the cycle to discuss the state-specific CAP template, the Cycle Summary Report and related Executive Summary, and state-specific error analysis findings that the contractors prepared.

State Forum Call

CMS allows each state in the CAP phase of the PERM program to have a “State Forum Call” to discuss best practices related to developing corrective actions. While CMS provides the conference call line, a state volunteer from the cycle of states facilitates the discussions. After the first State Forum Call, states may decide whether they need a second call for further discussion.

Corrective Action Panel

The key to a successful CAP is the creation of a corrective action panel. The panel must encourage participation and commitment of top management to coordinate efforts across the state agency and ensure participation of major agency leaders.

The panel should include senior management, such as managers responsible for policy and program development, field operations, research and statistics, finance, DP, human resources (for staff development), and the legal department. Panel leadership should rest with the state Medicaid or CHIP Director.

Responsibilities of the corrective action panel include:

- ▶ Providing insight on possible error causes
- ▶ Communicating CAP progress to management and other stakeholders
- ▶ Developing strategies
- ▶ Making all major decisions on the planning, implementation, and evaluation of corrective actions

Components of the Corrective Action Plan

States will receive a pre-populated, state-specific CAP template for both Medicaid and CHIP. States are required to complete every section of the CAP template and address every error and deficiency. The CAP template is based on information that went into the official state improper payment rate and will include errors that were overturned during continued processing. The PERM State Liaison will provide a CAP Addendum report to show any changes to final findings that occurred during continued processing. States can identify any overturned errors and reference them in the CAP and no corrective actions are required for these overturned errors. States cannot delete any portion of the CAP template and they must submit separate CAPs for Medicaid and CHIP. CAP instructions are included in SMERF under the CAP tab, along with the CAP checklist and CAP presentation.

CAPs are composed of five elements that are required by regulation. The five elements are: data analysis, program analysis, corrective action planning, implementation and monitoring, and evaluation.

Data Analysis

CMS pre-populates the CAP template with the number of errors and dollars in error for each qualifier within the error category. The template provides space for states to enter additional optional data analysis if they would like to provide more information about the nature of the error. Data analysis enables the state to gain a more thorough understanding of the root cause of the errors, when the errors occurred, and who or what caused each error. For example, an error accounted for 10% of the total errors identified during the MR, resulted in a total overpayment of \$100, or occurred because the provider did not maintain personal care assistant documentation in accordance with state policy to support the ten units of procedure code T1019 (Personal care services, per 15 minutes) it billed for the date of service sampled.

Program Analysis

Program analysis is the most critical component of the corrective action process, requiring the state to review the data analysis findings to determine the specific cause of each error. The state must identify the root causes of the errors to determine the best solutions for each (e.g., why providers are not complying with MRRs). The state may need to analyze its operational policies and procedures to identify those policies and/or procedures that are more likely to contribute to errors (e.g., policies are unclear, lack of operational oversight at the local level).

Program analysis, along with data analysis, provides the framework to evaluate the relevant facts and causal factors and develop the most appropriate, timely corrective actions needed to resolve the finding and prevent recurrence. For example, if inadequate training caused errors, the state should take actions to strengthen its training programs, including actions like worker interviews, questionnaires, policy reviews, and conferences with local managers, etc.

The state must explain how its planned program analysis actions address 100% of the payment error types. Although a state may not be inclined to plan corrective actions for one-time error situations, such as human error, or corrective actions that are not cost-effective, it must at least address each error.

In its program analysis, the state should address all errors and deficiencies. The state should describe how its program analysis actions go beyond the surface cause (nature) of each error and look to the root causes. The state should describe actions it is taking to meet or exceed its PERM improper payment rate target, as specified by CMS. The state also should discuss why a particular program or operational procedure caused a specific error and identify the root causes of all errors.

Corrective Action Planning

Based on its data and program analysis, the state must determine what corrective actions to implement. CMS encourages the state to use the most cost-effective corrective actions possible, to best correct and address the root cause of each error. Actions can be short-term or long-term. Benefits of implementing corrective actions include the reduction of improper payments and the development of a management tool to promote efficiency in program operations.

The state must address each error type, but may decide what corrective actions it takes to decrease or eliminate errors. It may not be cost-effective to implement corrective actions for each error. CMS understands these situations and does not encourage states to make inefficient fixes. It may be helpful for the state to perform a cost/benefit analysis to calculate the total expected costs of corrective actions and weigh them against the actions' expected benefits. If the state determines the cost to implement a corrective action outweighs its likely benefits, the state may choose not to implement the corrective action. If the state chooses not to take definitive corrective action, it should explain its decision in the CAP, along with its rationale (e.g., quick fix, no potential cost savings, resource constraints, etc.).

The state should explain its overall approach toward CAP planning, identify its PERM improper payment rate target goal (as specified by CMS), and explain actions the state is taking to meet its target goal. The state should describe its planned corrective action initiatives and how these actions will reduce or eliminate improper payments, including:

- ▶ Specific error causes being targeted
- ▶ A timeline listing expected due dates for resolving the problem(s) (causes of errors)
- ▶ Description of the plan to monitor CAP implementation
- ▶ Specification of the name and title of the person who has overall responsibility for the CAP

Implementation and Monitoring

The state should develop a schedule to perform corrective actions and describe the tasks necessary to implement the CAP, linking those tasks to the schedule and specifying milestones and implementation dates. The state should note whether the corrective action is statewide or just in certain geographical areas. The implementation schedule must identify major tasks, key personnel or components responsible for each task, a timeline for each task (including target implementation dates), milestones (e.g., start dates, final implementation dates), and the monitoring process.

Federal regulations also specify that states must monitor their CAPs to determine whether the implemented CAP yields intended results and helps states meet identified error reduction goals. Monitoring activities are ongoing, operational actions the state takes while implementing its CAP. Monitoring activities enable the state to keep track of its ongoing efforts to reduce its PERM errors. An integral part of successful CAP monitoring is maintaining a systematic approach to track and report the status of corrective actions until successful closure and implementation.

The state should describe its CAP evaluation activities and describe actions taken to monitor CAP implementation.

Evaluation

The state must evaluate the effectiveness of its corrective actions by assessing improvements in operations and/or error reduction. The state may then decide to discontinue, modify, or terminate and replace one or more of its corrective actions. The state must evaluate the corrective actions it implements by assessing:

- ▶ Improvements in operations
- ▶ Efficiencies
- ▶ Number of errors
- ▶ Improper payments

Evaluation of Previous Cycle CAP

As part of its new CAP, the state must evaluate and include updates on the corrective actions taken in its prior cycle, including:

- ▶ Effectiveness of implemented corrective actions using reliable data, such as performing special studies, state audits, focus reviews, etc.
- ▶ When the action was implemented
- ▶ The status of the corrective action (e.g., completed or still in progress)
- ▶ Expected completion date and if the corrective action is on target
- ▶ Actions not implemented, and those actions, if any, that were substituted, ineffective, or abandoned and what alternative actions it took
- ▶ Findings on short-term corrective actions
- ▶ Status of long-term corrective actions

- ▶ Determination of if the state met the PERM improper payment rate targets CMS identified

The state also should use the Medicaid FFS and managed care comparisons information in its Cycle Summary Report to evaluate the effectiveness of the corrective actions it took in the previous cycle.

Corrective Action Plan Submission Details

The state must submit CAPs to its assigned PERM State Liaison no more than 90 calendar days after the date on which the RC posts its improper payment rates on SMERF. However, CMS encourages states to submit drafts to their designated PERM State Liaison before the due date to receive feedback before submitting their CAPs. While drafts are not required, they are strongly encouraged. Once the state submit the drafts, CMS will review them and provide additional feedback that states can incorporate into their final CAP submission. The state submits final CAPs to its CMS PERM State Liaison for review and distribution to the members of the CMS collaboration workgroup, which includes the CMS State Liaison, the state RO representative, CPI representatives, and the PERM contractors. Each state will receive a letter of receipt acknowledging its final CAP submission. After all parties review the CAPs, the parties may conduct individual calls with the states for further discussion.

The CAP instructions are in SMERF under the CAP tab, along with the CAP checklist and CAP presentation.

Post-CAP Submission Activities

March through end of May — After all CAPs have been evaluated, the PERM State Liaison, CMS RO PERM contact, designated CPI staff, and the PERM contractors participate in a conference call with each state to discuss the findings, request clarification, and determine if additional information is needed.

Webinars — Each state is required to have a post-CAP webinar to facilitate active dialogue between the state, CMS, ROs, CPI, and CMS' contractors. CMS presents information to the state on PERM initiatives and proposed improvements to the next PERM measurement. The state is required to give an oral presentation of its CAP and CMS encourages presentations that provide a high-level overview of findings and mitigation strategies. Based on the meeting, states may need to submit revisions to their CAPs. States have 15 days from the meeting to submit revisions, if required. States must notify their CMS State Liaison of any major changes to their corrective actions such as implementation, modifications, terminations, etc.

Follow-up—The CMS State Liaison will contact the state on an annual basis to follow up on its CAP implementation status between cycles.

The state should expect to participate in the following CAP-related activities, including:

- ▶ Cycle Summary findings call
- ▶ Establishing a Corrective Actions Panel
- ▶ Best Practices teleconference call with CMS
- ▶ State forum call
- ▶ Working with the designated CMS State Liaison on an ongoing basis
- ▶ Submitting CAPs within 90 days after publication of the AFR (CMS State Liaisons will provide feedback and recommendations on drafts submitted in advance of the submission deadline)

3. PERM Initiatives and Available Resources

State Systems Workgroup

The State Systems Workgroup (SSW) is a collaborative group consisting of representatives from CMS, the SC, the RC, the ROs and the states to address state system issues. This group works together to identify underlying problems and discuss how those issues can be resolved. The SSW call typically occurs when states submit their final CAPs so the states can include those issues and related corrective actions in their CAPs. CMS will contact states if it identifies any issues and states are welcome to contact CMS at any time if they would like to discuss any program issues.

PERM Technical Advisory Group (TAG)

CMS established the PERM TAG as a forum to discuss technical and operational issues and share best practices relating to the PERM program. The TAG is composed of the CMS PARG Deputy Director, the PERM team, state Medicaid Directors, CHIP Directors, and state personnel such as managers, supervisors, and program integrity directors. The committee chairperson presides over meetings.

The CMS PERM staff member is the principal contact for the PERM TAG and works with the chairperson to prepare for each PERM TAG conference call by gathering agenda items and discussing protocol and work-planning issues. Each CMS Region has a TAG representative who normally serves as a member for one or two years. Meetings are quarterly in January, April, July, and October. The TAG website is located at <https://www.cms.gov/perm>.

The TAG provides a venue for open discussions and allows states to offer feedback on PERM issues. The TAG also informs and advises CMS by preparing guidance and regulations, reviewing operational policies, and identifying and resolving PERM-related issues.

Mini-PERMs

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

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

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

Findings will not cause a state’s PERM sample size to go up (or down). In addition, “Mini-PERM” work qualifies for the same federal administrative matching as the normal PERM cycle work. In general, “Mini-PERMs” are a strong program integrity effort without the states expending significant resources.

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

CMS Contacts

Cycle Topic	Contact
<i>Overall Cycle Activities & Cycle Calls</i>	Tracy Smith 410-786-8418 Tracy.Smith@cms.hhs.gov
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Appendix A

SAMPLE PROVIDER EDUCATION LETTER

Dear State:

With the national implementation of the PERM program to measure improper payments in Medicaid and the Children's Health Insurance Program (CHIP), we recommend that you educate your program providers about the importance of their cooperation and participation in timely submitting complete medical records to help us evaluate the accuracy of claims payments. You can begin educating your providers now even if the PERM program does not review your state this year. To that end, we have provided draft language below that you may find helpful in your provider outreach efforts, writing a notice for placement in provider newsletters or other announcements such as remittance notices or posting to your state websites.

Dear Provider:

The Improper Payments Information Act of 2002 directs federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to review annually, programs that are susceptible to significant erroneous payments and report the improper payment estimates to Congress. OMB identified the Medicaid program and Children's Health Insurance Program (CHIP) as at risk for erroneous payments. The Centers for Medicare and Medicaid Services (CMS) will measure the accuracy of Medicaid and CHIP payments made by states for services rendered to recipients through the Payment Error Rate Measurement (PERM) program.

CMS uses contractors to measure improper payments in Medicaid and CHIP. Your interactions in collecting and submitting medical records for PERM review will be primarily with our review contractor, who will collect medical policies from the state and medical records from you, either in hardcopy or electronic format.

Our PERM review contractor must review medical records as it reviews FFS Medicaid and CHIP claims to determine if the claims were correctly paid. If a claim selected in a sample for a service you rendered to a Medicaid or CHIP recipient identifies your provider number to receive reimbursement, the CMS contractor will contact you for copies of the medical records required for MR of the claim. For reviews that require extra information, the contractor will contact you for additional documentation. You will then have 14 calendar days to submit the requested additional documentation.

Understandably, you are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a)(27) of the Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and provide CMS, or its contractors, with information regarding any payments claimed by the provider for rendering services.

Providing information includes medical records. As for CHIP, section 2107(b)(1) of the Act requires the CHIP state plan to provide assurances to the Secretary that the state will collect and provide to the Secretary any information required to enable the Secretary to monitor program administration and compliance and to evaluate and compare the effectiveness of states' CHIP plans. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes **is permissible** by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164. No special patient permission is necessary for you to release records to the PERM review contractor.

In order to obtain medical records for a claim sampled for review, the CMS contractor will contact you to verify the correct name and address information and to determine how you want to receive the request (e.g., facsimile or U.S. mail) for medical records. Once you receive the request for medical records, you must submit the information electronically or in hard copy within 75 calendar days. Please note that the provider identified on the claim to receive payment is responsible for ensuring that the CMS contractor timely receives all supporting medical records from all providers who rendered a service in connection with the claim payment under review. During this 75-day timeframe, the CMS contractor will follow up to ensure you submit the documentation before the timeframe expires. Your state officials may contact you to help identify the required documentation for submission.

It is important that you submit all requested documents in a timely manner because no response or incomplete documentation also count against the state as errors. Past studies have shown that no documentation and inaccurate documentation cause the most PERM MR errors. As such, it is important that you send requested information in a timely and complete manner. If you have any questions about this matter, please contact your state PERM contact (**Insert name and Contact Information Here**). Thank you for your support of the PERM program.

Appendix B

Differences in FY 2014 and FY 2017 PERM Cycles

- Five significant changes to reviews:
 - Risk-based screening requirements for newly enrolled providers after 3/24/11 (including billing, performing and ordering/referring providers)
 - Risk-based screening revalidation requirements for all providers by 3/24/16 or 9/24/16
 - Fingerprinting and Criminal Background Checks are required to be fully implemented for all high risk provider types by 7/1/18
 - HIPAA 5010 transaction standards for electronically filed institutional and professional claims after 7/1/12
 - ICD-9-CM code sets replaced with ICD-10-CM code sets for discharges on or after October 1, 2015
- Changes to DP, MR, and MRR orientations
- Introduction of SMERF 3.0 hosted by the RC, which now includes the ability to track and report multiple errors on a single claim
- States will no longer receive monthly FEFR reports, only one EOC FEFR will be published after all findings are final

FY 2014	FY 2017
FFS Stratification by 4 service types and “other” category	Back to previously used 10 payment strata (with the addition of a fixed payment strata) and zero/denied stratum
	Changes to MR and DP error codes and qualifiers (reasons for errors) <ul style="list-style-type: none"> • Additional MR and DP error codes • Expanded qualifiers for specificity
PERM RC specific record request letters	MRR letters are now standard to match all CMS request letters sent to providers

FY 2014	FY 2017
No RC SFTP site	The RC will establish SFTP accounts for each state to facilitate submission and retrieval of documents with PHI
States emailed RC lead reviewer pending DP documentation	States will submit all documentation to the RC's central office in Rockville
ICD-9 code sets used to report medical diagnoses and inpatient procedures	Replaced with ICD-10 code sets on or after October 1, 2015
P1 reports for pending DP reviews not dynamic	<ul style="list-style-type: none"> P1 reports now dynamic and updated real time with weekly SMERF notices to track aging pending DP reviews
Only 1 DP error and 1 MR error could be identified on a sampled claim	All DP errors and MR errors can be cited on a sampled claim, so states know about all issues and can take action
Individual state orientation calls	RC will host combined educational webinars with states to cover DP, MRRs and MR. In addition, the RC will have individual check in calls with each state throughout the cycle, as needed.
DP orientation meetings used to be scheduled for at least two days	The RC will hold individual state Introductory Webinars that focus on the systems questionnaire, state systems review, and the identification and gathering of state security forms to facilitate DP reviewer access to state systems.
DP orientation meetings used to be primarily on-site	DP orientation meetings will be conducted through conference call/webinar as much as possible (where appropriate)

FY 2014	FY 2017
Systems questionnaires used to be distributed one month before DP orientation meeting	The RC will distribute systems questionnaires to all states at once to allow adequate time to complete for each system that must be reviewed
Issues were identified with states not being prepared for on-site visits when scheduled	The state must complete the new state DP Checklist prior to on-site visit to confirm that it has made all necessary arrangements.
On-site DP review weeks used to average 2-3 weeks per state	<p>On-site DP review visits will range from 3-8 weeks per state depending on sample size and number of systems to review. Please keep in mind that states are strongly encouraged to provide the RC system access. Read-only remote access to systems for the DP reviewers is the preferred method, to minimize disruption at the state.</p> <p>The following list comprises information needed to complete reviews. If system access is not provided, this information will need to be supplied by the state.</p> <ul style="list-style-type: none"> • Eligibility • MMIS • Dental • PBM • Provider Enrollment • Risk-Based Screening • Document Repository • EDI/Paper Claims • Fixed Payments • Capitation Rates • Capitation Payment History Screens • Geographical Service Areas (counties, zip code) • Managed Care Contract for Sampled Claims • Population Carve-outs • Service Carve-outs • Rate Cells