	MIC	Medicaid RAC	PERM
Authority	Section 1936 of the Social Security Act ("the Act") as created by section 6034 of the DRA of 2005.	Section 1902(a)(42) of the Act as created by section 6411(a)(1) of the ACA; 42 CFR §455.500 *et seq.*	Improper Payments Information Act of 2002 (IPIA; Public Law 107-300); amended in 2010 by the Improper Payments Elimination and Recovery Act (IPERA; Public Law 111-204).
Purpose	To review and audit Medicaid claims, to identify overpayments and to educate providers, beneficiaries and others regarding program integrity and quality of care.	For States to contract with one or more RACs for the purpose of identifying underpayments and overpayments and recouping overpayments of Medicaid claims.	To measure and report a national error rate annually for Medicaid and the Children's Health Insurance Program (CHIP).
Programs Audited/ Measured	Any Medicaid provider may be audited including, but not limited to, fee-for-service (FFS) providers, institutional and non-institutional, as well as managed care entities.	Medicaid FFS claims paid under the State Plan and under any waiver of the State plan. States may exclude managed care claims.	3 components within Medicaid and CHIP: • FFS • Managed care • Beneficiary eligibility
Scope	Nationwide.	Nationwide, on a State-by-State basis.	Nationwide, on a 3 year rotational basis (17 states measured annually).
Contractors	As of January 9, 2012: Review MICs: AdvanceMed Corporation (Regions V, VI, VII, VIII, IX, X); Thompson Reuters (Regions I, II, III, IV). Audit MICs: IPRO (Regions I,II); Health Integrity (Regions III, IV, V, VI, VII, VIII) and IntegriGuard (Regions IX, X) Education MIC: Strategic Heath Solutions	As of January 1, 2012: State specific contract(s) with a RAC(s).	Statistical Contractor (SC): The Lewin Group: • Collects universe of claims data for Medicaid and CHIP FFS and managed care from the States • Draws random samples of claims from the universes for each state • Reviews and approves state eligibility sampling plans • Calculates national and state-specific error rates based on review findings Review Contractor (RC): A+ Government Solutions: • Collects state Medicaid and CHIP policies • Conducts data processing reviews on all sampled FFS claims and managed care payments • Contacts providers to obtain FFS medical records • Completes medical reviews on FFS claims
Audit/Measurement Standards	Audits of Medicaid providers conducted to ensure proper payments in accordance with Federal and	Medicaid RACs will engage in review of Medicaid claims submitted by providers of services or other individuals	*Fee-for-Service and Managed Care Component* PERM uses the SC for universe collection and

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	State Medicaid regulations and policies.	furnishing items or services to determine whether providers have been underpaid or overpaid, and to recover any overpayments identified.	sample selection. The RC collects State policies and uses the information collected from the SC to make medical record requests and complete medical and data processing reviews. No medical review is conducted on managed care payments. *Eligibility Component* States select random samples each month, review each sampled case for eligibility, and then collect payments for services received in the sample month. States perform their own eligibility reviews according to State and Federal eligibility criteria. States must submit all monthly findings to CMS according to the PERM eligibility timeline. The SC uses all findings to calculate error rates for each program.
Time Frame Measured / Look Back Period	Generally, a 5-year look back period from date of audit engagement letter.	3-year look back period from date of claim payment (consistent with Medicare RAC audit period), unless RAC receives approval from the State, and the State requests and is granted an exception from CMS.	Measures payments made in current Federal fiscal year. However, the measurement cycle is about 26-28 months.
Recoupment Activities	State recoups from provider. The State has 1 year to return Federal financial participation (FFP) to CMS once the State is notified of an identified overpayment amount.	States have discretion on how they will coordinate with Medicaid RACs to recoup overpayments. States have up to one year to recover overpayments before an adjustment is made in the Federal payment to the State to account for that overpayment. The Federal share of collections should be reported when received, if collected in the one year period. At the end of that period, the Federal share of the uncollected overpayment amount must be refunded to the Federal government.	Requires Corrective Action Plan (CAP) 90 calendar days after State is notified of its error rates. Tracks recoveries of overpayments collected by CMS Regional Offices. State has 1 year to pay back FFP to CMS once it is notified of the overpayment amount.
Appeal Process	State adjudication process.	States must have an adequate appeal process in place for providers to appeal any adverse determination made by the Medicaid RAC.	A State can dispute a FFS or managed care error through the difference resolution and CMS appeals processes. A State can dispute an eligibility error through its State appeals process.
Timeframe for Response to	Generally, providers have 30 business days to respond to document request. Provider may request	Each State has discretion regarding the administration of its Medicaid RAC program, including timeframes for responses	Provider has 75 calendar days to respond to documentation request and 14 calendar days to

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Documentation Request	an additional 15 business days extension if justified.	to document requests. States must set limits on the number and frequency of medical records to be reviewed by RACs.	submit additional documentation if needed.
HIPAA Compliance	Complies with HIPAA, does not need a business associates agreement with providers to obtain information.	Complies with HIPAA, does not need a business associates agreement with providers to obtain information.	Complies with HIPAA, does not need a business associates agreement with providers to obtain information.
Record Retention Requirement	Maintains records and files in accordance with the Privacy Act of 1974, 5 U.S.C. § 552a, Public Law No. 93-579.	Requirements are unique to each State's law, regulation or policy regarding record retention.	Maintains records and files in accordance with the Privacy Act of 1974, 5 U.S.C. § 552a, Public Law No. 93-579.
Photocopying Reimbursement	Does not reimburse for photocopying of documents.	States and RACs are not required to reimburse providers for photocopying of documents.	Does not reimburse for photocopying of documents.
Associated CMS websites	Medicaid Integrity Program general information is posted on the CMS website at http://www.cms.gov/MedicaidIntegrityProgram/ National Audit Program information is available at http://www.cms.gov/ProviderAudits/	The following CMS website summarizes the status of each jurisdiction's RAC program, based on the information submitted in its State Plan Amendment: https://www.cms.gov/medicaidracs/home.aspx. Additional information will be posted on Medicaid.gov in the near future.	PERM Website: http://www.cms.gov/PERM/ PERM State Medicaid Error Rate Findings (SMERF) website: https://smerf.healthdatainsights.com/ PERM Eligibility Tracking Tool (PETT) website https://www.cmspett.org
TAG Affiliations	Medicaid Fraud & Abuse TAG.	Medicaid Fraud & Abuse TAG.	PERM TAG