Payment Error Rate Measurement (PERM)

Eligibility Review Guidance for Medicaid and CHIP Benefits

May 2012

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Section 1 – Introduction

This guidance has been developed to support States in the Payment Error Rate Measurement (PERM) eligibility reviews. The Centers for Medicare & Medicaid Services (CMS) has compiled these instructions to provide guidance to States on the eligibility measurement process from initial sampling to final reporting. The instructions provide step-by-step guidance, charts and a timeline that illustrates the eligibility measurement process. As we work with all States and gain experience with the Medicaid and Children's Health Insurance Program (CHIP) eligibility measurement, we may consider program refinements that improve the process, for example, by improving the timeliness and accuracy of the reviews and by maximizing the use of limited resources.

1.1 – Improper Payments Elimination and Recovery Act of 2010

The Improper Payments Information Act of 2002 (IPIA), amended in July 2010 by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), Public Law 111-204, requires the heads of Federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments, estimate the amount of improper payments, to report those estimates to the Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures. The Office of Management and Budget (OMB) identified Medicaid and CHIP as programs at risk for significant improper payments. More information on the PERM program can be accessed at www.cms.gov/PERM.

To comply with the requirements of IPERA, CMS administers the PERM program. Under PERM, reviews will be conducted in three areas for both the Medicaid and CHIP programs:

- Fee-for-service (FFS)
- Managed care
- Program eligibility

The results of these reviews are used to produce national program error rates, as required under IPERA, as well as State-specific program error rates. CMS developed a national contracting strategy for measuring the first two areas, FFS and managed care. National contractors selected by CMS conduct the medical and data processing reviews to develop error rates in the FFS and managed care components for Medicaid and CHIP. States are responsible for measuring the third area, program eligibility, for both programs. Because States administer Medicaid and CHIP according to each State's unique program, the States necessarily need to be participants in the measurement process. CMS uses PERM to measure Medicaid and CHIP improper payments in a subset of States each year. States are reviewed on a rotating basis, so each State is measured for improper payments in each program once every three years.

The States that will be measured for fiscal years (FY) 2011-2013 (which rotate thereafter) are as follows:

Figure 1-1: States Selected for Medicaid and CHIP Improper Payments Measurements

FY 2011	FY 2012	FY 2013
Alaska	Arkansas	Alabama
Arizona	Connecticut	California
District of Columbia	Delaware	Colorado
Florida	Idaho	Georgia
Hawaii	Illinois	Kentucky
Indiana	Kansas	Maryland
Iowa	Michigan	Massachusetts
Louisiana	Minnesota	Nebraska
Maine	Missouri	New Hampshire
Mississippi	New Mexico	New Jersey
Montana	North Dakota	North Carolina
Nevada	Ohio	Rhode Island
New York	Oklahoma	South Carolina
Oregon	Pennsylvania	Tennessee
South Dakota	Virginia	Utah
Texas	Wisconsin	Vermont
Washington	Wyoming	West Virginia

States sample and conduct the eligibility reviews of Medicaid and CHIP cases. CMS' Statistical Contractor will calculate and combine the State eligibility error rates to develop national eligibility error rates for Medicaid and CHIP.

States must conduct the eligibility measurement using entities independent of States' Medicaid and/or CHIP eligibility determination and enrollment activities and have the option to hire a review contractor to administer the eligibility reviews.

1.2 – Children's Health Insurance Program Reauthorization Act of 2009

On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub L 111-3) was enacted. CHIPRA required a new PERM final rule and requires harmonization of the PERM and MEQC programs. Beginning in FY 2009 (with the enactment of CHIPRA) States were allowed the option to use their eligibility review and payment review findings from the MEQC reviews to meet the PERM eligibility requirement for Medicaid and Title XXI Medicaid expansion. More information on the substitution is given in these instructions. The PERM final rule, effective September 10th, 2010, allows the option for States to use eligibility data for

Medicaid and Title XXI Medicaid expansion PERM reviews to comply with the “traditional” MEQC statutory requirements, under certain conditions. Allowing data substitution minimizes the duplication of effort between MEQC and the PERM eligibility reviews. CMS Central Office will coordinate with the CMS Regional Offices to monitor States substituting data while States will continue to use the PERM eligibility review tracking website. CMS continues to consider methods to minimize duplication of effort regarding the eligibility reviews.

Section 2 – Eligibility Overview

The eligibility component of PERM will result in the calculation of an error rate to determine what percentage of Medicaid and CHIP payments made for services to beneficiaries were improperly paid due to erroneous eligibility decisions. For PERM eligibility sampling and review, States are responsible for identifying the appropriate sampling universe (per these guidelines), sampling, reviewing, identifying payment amounts for sampled cases, and reporting the results. Before sampling begins, States must develop a sampling plan that will be reviewed and approved by the CMS statistical contractor. The sampling plan will specify how the error rate for each State will be measured by creating a universe of beneficiaries, pulling a random sample, and reviewing the sampled cases.

States will draw a sample of cases each month of the Federal fiscal year in which they are participating in PERM (see Section 4). For the purposes of PERM eligibility, a case is an individual beneficiary or family enrolled in Medicaid or CHIP or a beneficiary or family who has been denied enrollment or terminated from either program. Each monthly universe will be broken into two main groups: active cases and negative cases. Active cases are those in which an individual or family is an active enrollee in the Medicaid or CHIP program in the month of the sample. Negative cases are those that are denied or have a termination effective date in the month of the sample, according to the enrollment file relevant to that month.

Once the sample has been drawn, States will review each case to verify eligibility according to State policies and procedures, as well as the procedures outlined in Section 5 of this guidance as they pertain to the State's programs. For sampled active cases, States will also identify payments for services received in the sample month and paid in the sample month and the four subsequent months (see Section 6). Each State is also responsible for reporting the monthly samples, the active and negative review findings, and the payment review information to CMS (see Section 8).

The payment error rate for PERM is 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. The eligibility component, however, is more complex in that the results from the eligibility reviews will include eligibility errors based on erroneous decisions as well as payment errors that result from the eligibility errors (i.e., liability understated, liability overstated, eligible with ineligible services and managed care errors).

Therefore, the eligibility review will allow CMS to calculate three eligibility error rates for each State:

- The active case error rate—the percentage of the decisions in which eligibility is granted incorrectly and the case is Not Eligible (calculated from the active case review findings);
- The active case payment error rate—a dollar-weighted error rate based on the number of dollars paid in error due to services being provided to an individual who was not eligible for those services (calculated from the active case payment review findings); and

- The negative case error rate—the percentage of the decisions in which eligibility was incorrectly denied or terminated (calculated from the negative case review findings).

It should be noted that the case error rates for active cases and negative cases are not included in the eligibility payment error rate. The eligibility payment error rate is a dollar weighted error rate and the rate that is included in the national Medicaid and CHIP program error rates with the fee-for-service and managed care component error rates.

Section 3 – Sampling Plan

Each State must submit a Medicaid and CHIP eligibility sampling plan to CMS by August 1 prior to the Federal fiscal year in which each State is participating in PERM. CMS will contact States prior to the cycle to inform them of the designated CMS staff responsible for collecting sampling plans. The purpose of the sampling plan is for the State to identify how it will conduct each phase of the PERM eligibility reviews – sampling, review, and payment collection as well as specific details to assist CMS in understanding each State's approach (e.g., who will conduct the sampling and reviews, which systems will be used, how the State will employ quality control mechanisms). CMS' statistical contractor will review each State's sampling plans and work with States to develop a final plan for approval by October 1 of the fiscal year. Part of the review process may include a teleconference or onsite between the State, CMS, and the statistical contractor prior to plan approval. Once a State has an approved PERM eligibility sampling plan, in subsequent cycles, States may submit revisions via an addendum to the sampling plan that was submitted in the previous cycle and do not necessarily need to submit a whole new sampling plan.

Sampling plans generally should include the following information:

- State name
- Program (e.g., Medicaid or CHIP)
- Timeframe for sample (e.g., FY 2013)
- Name of independent agency responsible for PERM eligibility reviews
- Name, phone number, and email address of person responsible for answering questions relating to the sampling plan
- Description of the eligibility appeals process that will be employed by the State
- Name, phone number and email address of person responsible for answering questions related to the eligibility appeals process
- List of the agencies in the State that make eligibility determinations and a State agency contact responsible for overseeing eligibility appeals (if applicable)
- Whether or not the State has self-declaration policies and under what circumstances self-declaration is acceptable
- Description of MEQC activities for the current fiscal year
- Description of the eligibility systems from which the data is pulled
- Description of the active case universe and sampling process, including:
    - The data sources for the active case universe and how unique individuals or family units will be identified and included in the universe for sampling
    - Description and explanation (if necessary) of exclusions from the active case universe for Medicaid and CHIP, including how cases under beneficiary fraud will be addressed

and that cases enrolled in Medicaid or CHIP using Express Lane Eligibility are excluded (if applicable)

- Description of strata (if applicable)

- Sampling unit chosen (individual or family)
- Sample size and explanation for how sample size was determined
- Description of how the monthly sample will be drawn, including an oversample if necessary
- Description of the quality control procedures that will be applied to ensure the completeness of the population from which the sample is drawn
- Description of how records of claims and managed care payments associated with the cases sampled will be obtained and the time period for which they will be obtained
- Description of the negative case universe and sampling process

In the sampling plans, States must not only identify that PERM guidance will be followed but must also convey how each activity will be conducted. **The State must ensure that what is described in the sampling plan represents actual circumstances and does not cite the eligibility review guidance verbatim if the guidance does not reflect the State's actual sampling procedures.** The statistical contractor will review each sampling plan to determine if all required components are included and to determine if the State sufficiently demonstrated its understanding of the PERM eligibility requirements and the State's ability to conduct the measurement in accordance with the eligibility guidance and the State's sampling plan. The statistical contractor will be available to help the States understand the guidelines and revise its sampling plan to conform with the guidance in areas where the State's sampling plan does not adequately conform to the guidance.

Section 4 – Sampling

This section provides the statistical and operational guidance for sampling cases which will be used to estimate eligibility error rates for Medicaid and CHIP. The programs are measured separately. It is important to note that, for purposes of the PERM reviews, cases included in the Medicaid universe are those where all services are paid with Title XIX funds, and cases included in the CHIP universe are those where all services are paid with Title XXI funds, including Medicaid expansion cases that are funded under CHIP. The universe should also include cases for which any State agency, in addition to the primary State agency responsible for eligibility determinations made a decision to either grant eligibility or deny or terminate eligibility for Medicaid or CHIP[1]. Although States will draw separate samples for Medicaid and CHIP, the procedures for sampling are the same for both programs. These instructions will distinguish between Medicaid and CHIP only when differences occur (e.g., exclusions from the universe).

4.1 – Eligibility Sampling Unit

The PERM eligibility sampling unit is referred to as a "case" and is defined as an individual or family. (Note: A "family" may include just one beneficiary.) States have the option to choose the sampling unit, either individual or family (e.g. assistance unit, assistance group, etc.)

States that sample at the individual beneficiary level will report the total number of individual beneficiaries in the universe each month. States that opt to sample at the family level will report the total number of families in the universe each month. Sampled cases will be reviewed for all eligibility categories for which eligibility was deemed, e.g. a long term care Medicaid recipient that is enrolled in QMB, although sampled as one case, must have the long term care and QMB determinations reviewed for eligibility.

4.2 – Active Case Sample

States will select a sample each month from the unique universe created for that month. The active case universe for a given month consists of active cases on the program at any time during the month.

[1] Please see Section 5.4 – Other Eligibility Review Situations regarding the treatment of 100 percent Federally funded cases.

4.2.1 – Identifying the Active Case Universe

An active case is a case that contains information regarding a beneficiary enrolled in the Medicaid program or in the CHIP program in the sample month.

Exclusions from the active case universe are:

- All cases that were denied or terminated (Note: These cases should be included in the negative universe)
- Cases under active fraud investigation (as defined in Appendix B[2])
- State-only funded cases for which the State receives no Federal matching dollars
- Cases that have been approved for Medicaid or CHIP using the State's "Express Lane" eligibility process[3] according to Section 1902(e)(13) or Section 2107(e)(1) of the Social Security Act (The Act) (These cases should also be excluded from the universe created for the MEQC reviews)
- For Medicaid only, Supplemental Security Income (SSI) cash cases in States with an agreement with the Social Security Administration (SSA) under Section 1634 of the Social Security Act
- For Medicaid only, adoption assistance and foster care cases under Title IV-E.

All other cases in which services are matched with either Title XIX or Title XXI funds should be included in the active case universe.

Cases still on the program pending the required 10 day notice of termination and cases where benefits are properly being continued pending an appeal of termination, should be included in the active universe.

4.2.2 – Spend Down Cases

Depending on how each State captures spend down case information, there may be a different method for how to address them in the PERM universes.

Denials: For States that capture spend down cases as denials due to excess income, these cases would be included in the negative case universe either monthly or at the six month redetermination (if eligibility is denied due to spend down not being met).

Pending: For States that capture spend down cases as pending applications, these cases would not be included in the active or negative case universes due to the case actions for these cases being incomplete. Include spend down cases in the active universe in the month when spend down is met and in the negative universe in the month when the certification period ends and the case is terminated.

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[2] If a case is terminated due to a final determination of beneficiary fraud, it should be placed in the negative case universe and will be considered a correct termination.

[3] Coding is only required for cases enrolled using Express Lane Eligibility (ELE). Active cases that do not meet the necessary thresholds to be enrolled under ELE should appear in the PERM and MEQC active case universes.

Active without receiving benefits: For States that capture spend down cases as active cases that are not receiving benefits States should include the case in the active universe for sampling and review according the guidelines presented in Section 5. Cases will be reviewed to ensure the accuracy of the calculated spend down amount but these cases may have no payment dollars collected if there were no services received in the sample month matched with Title XIX dollars.)

4.2.3 – Sample Size for Active Cases

Sample sizes must be sufficient to meet the precision requirements that the estimate of the error rate be within 3 percentage points of the true error rate with a 95 percent level of confidence. The base year sample size (i.e., the sample size to be used by States in their initial year conducting PERM eligibility reviews) was calculated under an initial assumption regarding the variance in the error rate. In the initial assumptions, the error rate was assumed to be 5 percent and the sample size sufficient to meet the precision requirements was calculated to 504 active cases.

After the base year, the State's sample size calculation will be based on the actual standard error associated with its more recent eligibility error rate estimate. If, in the State's more recent estimate, the precision requirements were exceeded, the sample size estimate will fall below 504. If, on the other hand, the State did not meet the precision requirement in its most recent estimate, sample sizes will increase above 504 cases. As a rule of thumb, if the State's eligibility payment error rate is below 5 percent, a smaller sample size may be sufficient to achieve the desired precision requirements. Similarly, States with eligibility payment error rates above 5 percent will generally be required to increase their sample size for the subsequent cycle. However, the actual sample size estimate will be based on the standard error of the most recently completed eligibility error rate, so that the rule of thumb may not apply in all instances.

The statistical contractor will calculate sample sizes for each cycle based upon the State's prior cycle eligibility error rate information. CMS has established a maximum sample size for eligibility at 1,000 active cases per program, regardless of a State's eligibility error rate in the prior cycle.

States in the base year will sample 42 cases each month for the 12-month Federal fiscal year (i.e., 504 cases/12 months). In subsequent cycles of PERM reviews, an equal number of cases should be sampled in each month, although the annual total may differ from the base year.

If the total population from which the total (full year) sample drawn is less than 10,000 individuals, the State may propose in its sampling plan to reduce the sample size by the finite population correction (FPC) factor (see in Appendix F).

4.2.4 – Method for Drawing the Monthly Active Case Sample

States will draw monthly samples over the course of the twelve-month fiscal year. After the end of each month, but no later than the 15th day of the subsequent month, the State should gather the universe data and sample cases from each month's universe.

There are two primary methods for States to use to draw a random sample: simple random sampling or a systematic random sample (i.e., the "skip" factor method).

- For simple random sampling, States should assign each case an integer from 1 to N, where N is the number of cases in the universe. Then, using a program that has a random number generator, such as Statistical Analysis Software (SAS), randomly generate enough integers in the range from 1 to N to meet the required sample size. For example, if the number of cases in the universe is 1,000, and a sample of 22 is needed, assign each case an integer from 1 to 1,000. The State would then generate 22 random integers between 1 and 1,000, without replacement. Cases that were assigned one of the randomly generated integers would be included in the sample.
- To use the "skip" factor method, divide the number of cases in the universe each month by the required monthly sample size. This number becomes the "skip" interval or N. Using a program that has a random number generator, such as SAS, randomly select a number from 1 to N to be the starting point in the universe. Select that case and then every N^{th} case until the required sample size is met. For example, if the number of cases in the universe is 1,000, and a sample size of 20 is needed, the skip interval would be 50. A random integer would be generated between 1 and 50 (inclusive of the end points). If this random number was 7, then, sample case number 7, case number 57, case number 107, etc. until the required 20 cases were drawn.
    - States may include oversample cases with the required cases when using the "skip" factor method. As discussed later in this section, States may want to draw an oversample to account for any problems that are discovered in the sample (active beneficiary fraud, etc.).
    - When using the "skip" factor method of sampling, the State has two options for selecting the oversample.
        1) The State may draw an initial sample that has a sufficient number of cases for the sample and oversample then randomly select the cases which will be considered the oversample cases. (Note: Taking the first two or last two cases as the oversample is not random.)
        2) Alternatively, the State may conduct a second systematic random sample to select the oversample but would first need to remove the cases that were initially sampled from the universe used to select the oversample.

Although unlikely, cases may be randomly sampled in more than one month. If a case is selected in more than one month, it should not be dropped and replaced with another case but should be retained in the sample.

4.3 – Negative Case Sample

Negative cases are cases where the State denied an application or terminated eligibility at redetermination. The sampling plan for negative cases should be included within the sampling plan for submission to the statistical contractor.

4.3.1 – Identifying the Negative Case Universe

A unique universe is created each month. All cases where the State denied eligibility or terminated eligibility should be included in the negative universe. Denied cases should be placed in the negative universe in the month the decision to deny an application was made (e.g., a case would be in the negative universe in November if the application was denied in November). Terminated cases should be placed in the negative universe in the month in which the termination takes effect (e.g., a case would be in the negative universe in November if the last date of eligibility is October 31and therefore the effective date of termination is November 1).

Exclusions from the negative universe include:

- Cases still on the program pending the required notice of termination,
- Cases that have a termination action but are still active until the end of the certification period
- Cases where benefits are properly being continued pending an appeal of termination (these cases should be placed in the active universe)
- State-only funded cases

4.3.2 – Sample Size for Negative Cases

The base year sample size of 204 negative cases is required in order to obtain a precision level of 3 percentage points at the 95 percent confidence level for the negative case error rate.

After the base year, if the State's negative case error rate is below 5 percent, a smaller sample size may be sufficient to achieve the desired precision requirements. Similarly, States with negative caseerror rates above 5 percent will be required to increase their sample size for the subsequent cycle. The statistical contractor will calculate sample sizes for subsequent years based upon the State's prior cycle negative case error rate information.

States in the base year will sample 17 cases each month for the 12-month Federal fiscal year (i.e., 204 cases/12 months). In subsequent cycles of PERM reviews, an equal number of cases should be sampled in each month, although the annual total may differ from the base year.

If the total population from which the total (full year) sample drawn is less than 10,000 individuals, the State may propose in its sampling plan to reduce the sample size by the finite population correction (FPC) factor (see in Appendix F).

States may want to employ similar testing and quality control activities to the negative universe as identified for the active universe to ensure the negative sample is drawn from a complete and accurate negative case universe.

4.3.3 – Method for Drawing the Monthly Sample

States will draw monthly samples from this universe of negative cases over the entire twelve months of the Federal fiscal year.

After the end of each sample month, but no later than the 15th day of the subsequent month, the State should determine the universe of negative cases for the month, draw the monthly sample, and submit it to CMS. The methods for drawing the negative case sample are the same as the methods described in **Section 4.2.4.**

The sampling plan should include an approach for drawing an oversample so that any cases that need to be replaced can be replaced with another randomly selected case. We do not anticipate that problems of this nature will occur often, so the size of the oversample should be small. If a State finds repeated errors in its universe or samples, the State must develop a revised universe approach to ensure that systematic errors in the universes are corrected before continuing with monthly sampling.

4.3.4 – Substituting Negative Findings

States in their PERM year have the option to use their negative PERM reviews to meet the MEQC negative case action review requirement. As discussed later in the document, States may still elect to substitute negative PERM findings even if they do not elect to substitute MEQC or PERM findings for active cases. In that instance, active case reviews will remain two separate processes.

4.4 – Timeframe for Creating the Monthly Active and Negative Universe

The active and negative case universes should be considered a "snapshot in time". The last action completed on a case and the date the universe is generated are important to note when determining if cases are correctly included in the active or negative case universes specifically for States that are not employing stratification in the active cases universe. Any actions that occur after the date the universe is generated are not considered during the sampling or review process. Below are examples of when the snapshot in time plays a role in the sampling and review process.

Example 1: The universe for October is created and the sample is drawn November 3rd. A case that was terminated on October 31st was reinstated on November 5th with retroactive coverage back to November 1st. Since the reinstatement would not be captured in time for the sample pull, the case is negative for October and active in November and will be reviewed as such.

Example 2: The universe for October is generated and the sample is drawn on November 10th. A case was reinstated on November 5th with retroactive coverage of November 1st. The reinstatement is captured in time for the sample pull and therefore the case is active in both October and November.

4.5 – Adjustments to the Monthly Sample

If a State discovers a sampled case should not have been included in the Medicaid or CHIP eligibility universe or a State identifies a problem with the Medicaid or CHIP eligibility universe that requires changes to the sample, States should contact the statistical contractor immediately with specific information regarding why the sample is being changed. If there are issues with the sample due to incorrect universe specifications (e.g., cases were incorrectly included or excluded from the universe prior to sampling), the statistical contractor will also need information regarding the number of affected cases in the sample as well as the potential impact of those cases on the submitted universe

totals (e.g., how many cases were incorrectly included/excluded from the universe). States will need to resubmit a revised sample list to the eligibility review tracking website if the issue is identified after the initial sample has been submitted.

Sampling situations that might require a State to adjust the sample and the universe after it has already been pulled include:

- A case is found to be under active beneficiary fraud investigation
- A case should have been excluded from the sampling universe but was inadvertently included in the universe and sampled (e.g., a State-only case was sampled)
- A case was enrolled in Medicaid or CHIP using States' Express Lane Eligibility processes, set forth in Section 1902(e)(13) and Section 2107(e)(1) of the Act although these cases should be coded in a way that they could be excluded from the sampling universe

The sampling plan should include an approach for drawing an oversample so that any cases that need to be replaced can be replaced with another randomly selected case. We do not anticipate that problems of this nature will occur often, so the size of the oversample should be small. If a State finds repeated errors in its universe or samples, the State must develop a revised universe (and stratum assignment, if applicable) approach to ensure that systematic errors in the universes are corrected before continuing with monthly sampling.

States are also encouraged to test their universe development and sample selection programming prior to the initial deadline of the first monthly sample due on November 15th of the Federal fiscal year under review. This could include developing monthly universes, according to the PERM programming requirements, in earlier months than the first month of the cycle (i.e., prior to October), selecting samples, and conducting a preliminary review of the samples to ensure that cases are appropriately included or excluded. Testing prior to selecting the first month's sample could prevent or reduce sampling issues and/or delays throughout the PERM cycle.

States may also consider capturing and storing the monthly universe information. This may assist them when attempting to isolate problems as they occur and still have access to the same universe information as it appeared at the time the universes are generated."

Note: States may not withhold monthly samples based on the need for correction of identified sampling problems without consulting the statistical contractor. States must allow the statistical contractor to assess any revised approaches to making corrections to the universes and samples.

Section 5 – Eligibility Reviews of Active and Negative Cases

While reviewing this guidance, particularly in Section 5, please ensure that PERM reviewers are reviewing cases based on the instructions in this document in conjunction with Federal regulations and guidelines, the CMS approved State plan and written State policies and procedures. If the State plan or State policies are silent, defer to Federal laws and regulations, including guidance in the State Medicaid Manual, State Health Official or State Medicaid Director letters.

The agency must record all case review findings in a separate "PERM case record" in which the PERM reviewer keeps worksheets, copies of relevant documents from the original case record, and documentation of all actions taken to obtain verification for the reviews, when applicable.

Please note that if a State is sampling at the individual beneficiary level, review all eligibility categories associated with the case, e.g. a long term care Medicaid recipient that is enrolled in QMB must have the long term care and QMB cases reviewed for eligibility. States sampling the family must review each member of the group and all associated categories.

5.1 – Review Month

For PERM purposes, the review month is the month when the State's last action occurred and should be the month for which eligibility is verified. The last action could be an annual or semi-annual redetermination or any change captured in the system that result in a redetermination of eligibility. For retroactive cases, the review month is the month that the decision was made for retroactive coverage was made and could be a month after the sample month. There is no administrative period for the PERM eligibility reviews[4].

The exception to verifying eligibility as of the review month is when the State's last action for a case occurred more than 12 months prior to the sample month. In that instance, eligibility for the case is verified as of the sample month. This does not apply to instances in which a State uses prospective eligibility to make a determination or conducted an eligibility review redetermination ahead of schedule, e.g. CHIP redeterminations for prospective eligibility.

Example 1: A case is sampled in January 2012. The State's last action occurred in May 2011. Eligibility for this case is verified as of May 2011 (the review month) because it occurred within the past 12 months.

Example 2: A case is sampled in January 2012. The State's last action was a redetermination that occurred in December 2010. Since the last action occurred more than 12 months prior to the sample month of January 2011, eligibility is verified for January 2011 (the review month).

[4] The administrative period is defined under 42 CFR §431.804 as a timeframe under the MEQC program that provides States with a reasonable period of time to reflect changes in the Medicaid beneficiary's circumstances without an error being cited. The administrative period does not apply to CHIP. This period consists of the MEQC review month and the prior month. We are not applying this concept to the PERM eligibility reviews because PERM cases are reviewed as of the State's most recent action.

Example 3: A case is sampled in January 2011. The State's last action was an annual redetermination which occurred on December 15, 2009 with an effective date of February 1, 2010. Although the last action occurred 13 months prior to the sample month of January 2011, the State would still review the case as of December 15, 2009 since the effective date of that redetermination was less than 12 months prior to the sample month.

If a case is sampled more than once over the course of the measurement process, determine when the State's last action occurred. If the action occurred within 12 months of each sample month, additional verification of eligibility is not necessary because eligibility already has been verified as of the State's last action when previously sampled and the same finding can be applied. However, if the action occurred beyond 12 months from the second sample month (exempt in the case of prospective eligibility), new eligibility verification is necessary as of the second sample month because case circumstances may have changed from the eligibility verification done when the case was previously sampled.

5.2 – Verification Standards

The purpose of the eligibility review is to verify the eligibility of sampled cases using State eligibility criteria in effect at the time of the decision under review. Resources that must be considered when reviewing cases for eligibility include:

- The State's CMS-approved State Plan
- State regulations
- State eligibility manuals
- Agency policy and procedural manuals and
- Other State documents or directives that reflect current policy and procedure.

If the State Plan or State policies are silent, reviewers should refer to the following Federal guidance:

- Federal laws and regulations
- The State Medicaid Manual
- State Health Official letters
- State Medicaid Director letters
- CMS Informational Bulletins
- Other written CMS guidance

The guidance discussed below determines the extent to which the review obtains evidence relevant to the beneficiary's eligibility or ineligibility. CMS created this guidance to provide a systematic and nationally uniform method of verifying eligibility for PERM. However, these verification standards are not all inclusive. If the agency is unable to obtain documentation specified, eligibility can be verified through other reasonable evidence. Other reasonable evidence could include, but is not limited to:

- Information from other beneficiary records, for example, the Supplemental Nutrition Assistance Program
- Third party sources
- Applicable caseworker notes
- Information obtained by the PERM reviewer over the telephone
- Documentation listed in Section 7269 of the State Medicaid Manual.

5.2.1 – Required PERM Verification

Verification and verified information must be present in the case record and current If all necessary verification is present and current, the agency may make a review decision based on the existing verification. If any elements are missing or outdated and likely to change, they must be independently verified using the verification standards below in **Section 5.2.2**.

5.2.2 – Acceptable Documentation

The agency must examine the evidence in the case record that supports categorical and financial eligibility for the category of coverage in which the case is assigned, and independently verify information that is: (1) missing, (2) outdated and likely to change, or (3) otherwise as needed, to verify eligibility. Outdated evidence is evidence that must be verified every 12 months and is older than 12 months prior to the sample month. Exhibit 5.1 lists examples of categorical and financial criteria that are likely and unlikely to change.

Depending on State policy and procedure, evidence in the case file could include:

- Eligibility worker notes, including documentation of client statement
- Written documentation of a face to face or phone interview
- Copies of documents provided from applicant or recipient
- Signed self declaration statements.

Exhibit 5-1: Examples of Likely to Change and Unlikely to Change Eligibility Criteria

Categorical Criteria Unlikely to Change	Financial Criteria Unlikely to Change	Categorical Criteria Likely to Change	Financial Criteria Likely to Change
Citizenship (in month eligibility is being verified)	Cash (resource[5])	Residency	Bank Account (resource)
Social Security Number	House, other property (resource)	Household Composition (for income relationship purposes)	Earned Income-e.g. wages and salary
Death	Vehicle (resource)		Unearned Income-e.g. RSDI, other government benefits, retirement income
Birth Date	Life Insurance (resource)		
Pregnancy (in month eligibility is being verified)	Personal effects-e.g. boat, camper (resource)		

Sufficient evidence of verification or verified information in the case record includes but is not limited to:

- Information on an application or redetermination form, including case worker notes from an interview
- Documentation from a reliable third party source, e.g., employer wage statement showing earned income for the month eligibility is being verified
- Caseworker notes in reasonable instances:
    - To verify residency: "Visit to Susie Jones at assisted living home. Ms. Jones is residing there"
    - To verify income: "Conducted a home visit and verified Bank of America statement for checking account #12345, dated March 2012, with an ending balance of $55.07 and no unusual deposits or withdrawals other than the Social Security benefit of $700"
- Copies of permanent documents (e.g., birth certificate, copy of Social Security card, regardless of when the document was obtained)

[5] States must only verify resources for the PERM eligibility review if there is a requirement to verify resources during the original eligibility determination. This may include ensuring the eligibility worker inquired or investigated property ownership in accordance with State and Federal policy (e.g. Medicaid Long Term Care cases).

- Information from other agencies or databases or electronic records as long as it does not conflict with Medicaid or CHIP case record information

Also refer to Section 7269 of the State Medicaid Manual (SMM) for a listing of acceptable primary and secondary documentation for certain eligibility criteria. This list is not all inclusive and other reasonable evidence may be used if this documentation cannot be obtained to complete the PERM review.

5.2.3 – Acceptable Self Declaration

CMS allows States to accept self-declaration or self-declared information of certain categorical and financial eligibility criteria as a means to simplify the application and redetermination eligibility processes.

Some States accept a signed statement for categorical and financial criteria as long as there is no Federal requirement to document the information, such as the Deficit Reduction Act of 2005 requirement to document citizenship for Medicaid. The Children's Health Insurance Program Reauthorization Act (CHIPRA) allows for States to verify citizenship for children enrolled in Medicaid and CHIP through the Social Security Administration (SSA)[6].

Elements of eligibility in which State policy allows for self-declaration or self-certification are considered to be verified with a self-declaration or self-certification statement. Self-declaration is considered acceptable verification for the PERM review to meet categorical and financial eligibility verification requirements as long as the information is not required by Federal law or regulation. The self-declaration or self-certification must be accepted in accordance with official written State policy and the information must be:

- Present in the case record
- Not outdated (more than 12 months old)
- Originating from the last case action that was not more than 12 months prior to the sample month
- In a valid, State-approved, format, e.g., signed under penalty of perjury
- Consistent with other information in the case file, or if inconsistent, other evidence in the case file resolves the inconsistency

If the self-declaration fails to meet these standards, the agency must verify the self-declaration with (1) a new self-declaration statement from the beneficiary for the month eligibility is being verified for Medicaid or CHIP or (2) other reasonable evidence to verify the appropriate information.

[6] States should refer to Federal Medicaid and CHIP eligibility rules at 42 CFR §435 and §457 for citizenship verification and other Federal verification requirements. For CHIPRA requirements that are not yet promulgated in regulation, refer to the State Health Official (SHO) letters, State Medicaid Director letters and CMS Informational Bulletins that provide the most up to date guidance.

PERM reviewers may conduct phone interviews with sampled beneficiaries to verify eligibility criteria if verification is missing from the case record. Reviewers should complete a worksheet or other instrument to document the interview, including the date and time of any contacts with the beneficiary and the beneficiary's statements. The worksheet or other instrument may then serve as documentation of a phone interview.

If a new self-declaration statement or self-declared information cannot be obtained and eligibility cannot be verified through other reasonable evidence, cite the sampled case as Undetermined.

5.2.4 – Simplified Enrollment and Passive Renewal for Applications and Redeterminations

The regulations at 42 CFR §431.980(d)(1)(vi) says that self-declaration statements as documentation is acceptable for PERM as long as they are (A) present in the record, (B) not outdated (more than 12 months old), (C) originating from the last case action, (D) in a valid, State-approved format and (E) consistent with other facts in the case record.

But 42 CFR §431.980(d)(1)(i), (ii) and (iii) tell States to review each case as of the last action in the case and in accordance to the State policies and procedures in place at the time of the review month. Many State policies and procedures, such as passive (automatic/administrative) renewal and ex-parte determinations allow documentation that is more than 12 months old. Also, documentation that originates from the last case action (in accordance with (D) above) could be more than 12 months old.

For passive renewals in particular, case record documentation will be more than 12 months old, especially if a recipient has not reported changes at their recertification time. For ex-parte determinations, information received from other State partners may be current at the time of a determination, but not current at the time of a PERM review.

Considering that State policy and procedure takes precedence, for the PERM reviews, the following applies:

- Self-declared information qualifies as acceptable self-declaration for PERM.
- Documentation that originates from the last case action is still acceptable verification for PERM even if more than 12 months old, particularly for applications with prospective eligibility and ex-parte determinations using data sources that are considered current at the time of the eligibility determination.
- If State policy is that when a beneficiary does not return their renewal form and the beneficiary is thus self-declaring and attesting that his/her circumstances are the same as the previous year, this self-declaration is considered current and acceptable for PERM when case record documentation is more than 12 months old.

  If State policy and procedure was followed and led to an automatic renewal in accordance with State policy, nothing new must be re-verified for PERM. However if a beneficiary returns their

renewal form to report changes, the eligibility worker must act and act appropriately, or it could result in a PERM error.

In these instances above, and all other eligibility reviews, if State policy is applied correctly and an eligibility worker acted according to the correct procedures, no further PERM verification is necessary and a review decision may be made from the applicable documentation. But if an eligibility worker did not take the necessary or appropriate actions, the PERM reviewer must attempt to resolve any inconsistencies in the case record in order to make a review decision.

5.3 – Process for Verifying Active Case Eligibility

The process for verifying Medicaid and CHIP eligibility is outlined below. Note that because CHIP has the requirement that applicants must first be screened for Medicaid eligibility, **Step 4** is added to this process to verify that the CHIP case is not Medicaid eligible.

Step 1: Determine the review month for the case. The review month is the month in which the last action was taken on a case, i.e., to grant or redetermine eligibility. If the last action was taken more than 12 months before the sample month, verify eligibility as of the sample month. (Note: Exceptions are made for prospective eligibility and continuous eligibility.**)**

Step 2: Determine the State criteria for eligibility (i.e., categorical and financial criteria to be met for the coverage group under which the case is being reviewed) and determine the documentation standards that apply to the case, including when self declaration is accepted.

Step 3: Examine the evidence in the case file that supports categorical and financial eligibility. Verify information that is:

- Missing
- Outdated and likely to change
- Inconsistent with other fact
- Unacceptable under self-declaration guidelines

Step 4: For CHIP cases, verify whether the beneficiary was screened properly under the States' approved screen-and-enroll process for Medicaid eligibility.

- If the beneficiary was properly screened and ineligible for Medicaid, continue to Step 5.
- If the beneficiary was not properly screened and is eligible for Medicaid, cite the case as "Not Eligible" for CHIP and proceed to Step 6.

Step 5: Verify program eligibility for the Medicaid or CHIP coverage group in which the person is receiving services based on acceptable documentation as described in **Section 5.2.2**. If the case is ineligible for the eligibility category in which the case is enrolled, review possible eligibility for other related categories. A case is still considered eligible for Medicaid or CHIP even if it is found to be enrolled in the wrong category.

Step 6: Use one of the following eligibility codes that best fit the main circumstance for any active case finding. It should be noted that some of the codes constitute payment errors and may not be identified until the payment review process. If a change in findings is necessary based on new information, States will be given the opportunity to change the review finding to one that is more appropriate:

- **Eligible**: A case meets the State's categorical and financial criteria for receipt of benefits under the program.
- **Not eligible[7]:** A case is receiving benefits under the program but does not meet the State's categorical and financial criteria being verified using the State's documented policies and procedures.
- **Eligible with ineligible services**: A case meets the State's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP program but was not eligible to receive particular services in accordance with the State's documented policies and procedures.
- **Undetermined**: The case record lacks or contains insufficient documentation, in accordance with the State's documented policies and procedures, to make a definitive review decision for eligibility or ineligibility.
- **Liability overstated**: The beneficiary overpaid toward an assigned liability amount or cost of institutional care and the State underpaid.
- **Liability understated**: The beneficiary underpaid toward an assigned liability amount or cost of institutional care and the State overpaid.
- **Managed care error 1**: Ineligible for managed care - Upon verification of residency and program eligibility, the beneficiary is enrolled in managed care but is not eligible for managed care.
- **Managed care error 2**: Eligible for managed care but improperly enrolled – The beneficiary is eligible for both the program and for managed care but not enrolled in the correct managed care plan as of the month eligibility is being verified.

Citing Undetermined Cases

If the agency cannot verify eligibility or confirm ineligibility using the case record documentation or other independent sources, the following process must be followed prior to citing a case as Undetermined. The State should contact the beneficiary to obtain the needed information if information cannot be obtained from other sources. **A missing case record does not automatically make a case Undetermined.** The PERM reviewer must build a PERM review case record.

[7] For family applications, if sampling at the application level or family level, if one individual in the family unit is identified as ineligible, then the case will be considered not eligible. However, the dollars in error will be identified as only those dollars associated with the individual in the family who is ineligible. This case review finding differs from MEQC, which would consider this case "eligible with an ineligible member". As the PERM eligibility review is focused on the eligibility decision rather than the beneficiary's eligibility at the time the case is sampled, for PERM, the case is considered "not eligible" for the purpose of calculating the case error rate.

The minimum efforts (all of which must be performed) required to contact the beneficiary are:

- Three phone calls to all valid known beneficiary phone numbers, on varying days and at varying times of day
- One certified letter to all known mailing addresses
- Two contacts with reliable collateral sources (e.g., relative, authorized representative allowed to provide information concerning the beneficiary)

Although due diligence includes beneficiary contact, beneficiary participation in PERM is not a condition of Medicaid or CHIP eligibility and a beneficiary must not be terminated or sanctioned for not complying with requests for information from a PERM reviewer. Federal regulations do not provide for beneficiary penalties for not complying with Federal audits.

When the State has followed the procedures above and is still unable to obtain sufficient information to verify eligibility through other reasonable evidence, the State may cite the case as Undetermined and proceed to Step 7. States can cite a case as Undetermined if, after due diligence, an eligibility review decision could not be made. States will report all Undetermined cases and payment amounts for these cases. If further documentation is received during the cycle, the case can be resolved with the applicable review findings.

Undetermined cases should not be dropped from review. The agency must record all actions taken to contact the beneficiary, including dates and times, before citing the case Undetermined.

Review all aspects of eligibility to ensure the accuracy of the entire determination. If one eligibility criterion cannot be verified, continue with the remainder of the review to ensure all other eligibility criteria can be verified.

Step 7: States may employ their eligibility appeals process (if applicable).

Step 8: Cases with error findings should be forwarded to the State agency responsible for eligibility determinations so appropriate follow-up actions can be taken. When a case is found to be ineligible, the case should not be terminated from the program based on the PERM review findings. The correct action is to refer the case to the State agency for a redetermination.

5.4 – Other Eligibility Review Situations

5.4.1 – Presumptive Eligibility

In order to facilitate and expedite the eligibility process in certain situations, under Federal law States may provide presumptive eligibility to certain groups of beneficiaries, which might include:

- Pregnant women

- Women whose eligibility for Medicaid is based on needing treatment for breast or cervical cancer
- Children
- People with disabilities being discharged from the hospital into the community (Section 6086 of the DRA that amends Section 1915 of the Social Security Act)

Presumptive eligibility for Medicaid and CHIP allows States to enroll beneficiaries, for a limited time, before a full eligibility determination is completed, if they also file a full application. These cases are reviewed according to State eligibility criteria for presumptive eligibility as long as they comply with the State plan and Federal law.

For PERM, verify whether the case is within the presumptive eligibility period. If so, cite the case as **Eligible**. If the case is not within the presumptive eligibility period, verify that, for Medicaid, an application was filed and the beneficiary is eligible for the program using the PERM review process in **Section 5.3**.

5.4.2 – 100 Percent Federally- Funded Cases

100 percent Federally funded cases are cases that are subject to funding under the Medicaid program, but many times the State Medicaid agency does not make the eligibility determination for these cases. Although rare for some States, if a 100 percent Federally-funded case is sampled, ensure that the case is categorically eligible (e.g. receiving Medicaid provided through Indian Health Services) and cite the case as **Eligible**.

5.4.3 – Continuous Eligibility

Continuous eligibility is when coverage is extended to a child at the time of application or redetermination for a predetermined period specified in the State plan (no longer than 12 months) without regard to changes in income or any other changes in circumstances (except death, relocation to a different State, reaching the age limit for continuous eligibility specified in the State plans, requests for disenrollment or, if on CHIP, becomes eligible for Medicaid).

To review cases in continuous eligibility status for PERM, verify eligibility as of the date the State took the action to grant continuous eligibility based on an application or redetermination. PERM reviewers may not apply information from the current month to make an eligibility review decision. All verification must be based on the month of the last action.

5.4.4 – CMS-Approved Waivers

CMS may approve waivers or demonstrations to allow States to waive certain eligibility determination requirements and offer benefits to applicants who normally would not be eligible for Medicaid benefits. CMS approved waivers could include:

- Natural disasters/States of Emergency
- Continuous Eligibility

- Delayed Redeterminations
- Presumptive Eligibility

If a case is sampled that is applicable to the CMS approved waiver or demonstration, the State must follow the policies and procedures under the approved waiver, so long as the review month of the sampled case is during the approved time period of the waiver. For waivers that allow continuous eligibility and delayed redeterminations, if the State's last action occurred more than 12 months before the sample month, verify the case as of the last action, and not the sample month, as States would in the normal review process.

5.4.5 - SSI Conversion Cases

For SSI conversion cases, Federal regulations at 42 CFR §435.1003 limit Federal financial participation to the end of the month after SSA notifies the State of the loss of SSI (if received before the 10th of the month) or until the end of the next month (if notification is received after the 10th of the month) and requires a "prompt redetermination of eligibility." In 1634 States, Medicaid eligibility depends on the receipt of SSI cash. When SSI cash is lost then Medicaid eligibility no longer exists on this basis and the State must promptly redetermine eligibility to see if the person is eligible under another category.

If sampled for PERM, the State will review the case for eligibility under other Medicaid categories. If the case is not eligible, the State should cite the case as **Not Eligible**.

5.4.6 – Spend Down Cases

If a spend down case is sampled from the PERM active case universe, review the most recent action to grant eligibility or redetermine eligibility. Determine if the spend down amount was calculated correctly and determine if the expenses used toward spend down were appropriately allowed and calculated correctly.

5.5– PERM Technical Errors

PERM technical errors are errors identified during the eligibility review that would not result in a difference between the amount that was paid and the amount that should have been paid.

Technical errors for purposes of PERM include, but are not limited to:

- Failure to follow State administrative procedures that do not affect eligibility if acceptable documentation is otherwise obtained that supports beneficiary eligibility
- Requirements for a separate Medicaid application (apart from CHIP screen-and-enroll requirements)
- Failure to apply for other program benefits for which the individual is eligible (e.g., TANF, SNAP) if the benefit, if received, would not impact eligibility

- Failure to locate a hardcopy case record or documents in the record when available evidence shows the documents were filed, or if acceptable documentation is otherwise obtained which supports that the beneficiary is eligible
- Failure to record proper verification of pregnancy if later documentation (e.g., baby's birth certificate, hospital records showing date of birth) established pregnancy in the month eligibility is being verified

States may document technical errors as appropriate and include analysis of technical errors and related corrective actions in their corrective action plans. States do not need to document technical errors on the PERM reporting forms. States may add to the list provided above depending on State policies that were misapplied but do not affect eligibility of a case.

5.6 – Process for Conducting Medicaid and CHIP Negative Case Reviews

The negative case review process, which is identical for both Medicaid and CHIP, is described below. The negative case reviews may be limited to the review of the case record. Personal interviews are optional.

The negative case findings codes are as follows:

- **Correct**: The negative case was properly denied or terminated by the State.

- **Improper denial**: An application for program benefits was denied by the State for not meeting a categorical and/or financial eligibility requirement but, upon review, is found to be eligible for the tested category or a different category under the program in accordance with the State's documented policies and procedures.

- **Improper termination**: During a redetermination, the State determined that an existing beneficiary no longer met the program's categorical and/or financial eligibility requirements and was terminated but upon review is found to have been eligible for the tested category or a different category under the program in accordance with the State's documented policies and procedures.

Step 1: Review the notice of action to identify the reason that the State denied or terminated eligibility. Reasons for denials and terminations of Medicaid or CHIP can be for any circumstances (i.e., reasons are not limited to denials or terminations based on income).

Step 2: Examine the evidence in the case file to verify whether the State's reason for denial or termination was correct. For example, if the case was denied due to excess income, review the income verification in the case file to determine whether it exceeded State income levels. For details on what

constitutes sufficient evidence in the case record, please see Section **5.2.2, Acceptable Documentation** or Section 7269 of the State Medicaid Manual.

Step 3: If the reason for the beneficiary's denial or termination of benefits was correct, cite the case **Correct**. If the reason for the beneficiary's denial or termination of benefits was incorrect, determine whether the evidence in the case record supports the negative action for any other reason. If no negative action can be supported, cite the case **Improper Denial** or **Improper Termination**.

If no evidence exists to support the denial or termination, especially if caseworker notes indicate that documents are filed in a case record but the documents are not present, verify the denial or termination through other reasonable evidence.

Step 4: Determine if an improper denial or termination could be eligible for another category. Refer improper denial and termination case findings to the State agency responsible for eligibility determinations so appropriate action on an individual case can be taken. The State may evaluate the beneficiary's possible program reinstatement.

Step 5: The State may employ its eligibility appeals process (if applicable).

Note: There must be evidence to support a negative action. Notice of negative action to the beneficiary is a Federal requirement (42 CFR §431.211 and 42 CFR §457.1180), as well as evidence in the case record to support the notice. There are no circumstances in which a negative case can be cited as Undetermined.

Section 6 – Payment Reviews of Active Medicaid and CHIP Cases

Payment reviews must be conducted to determine the active case payment error rate, which is a dollar-weighted error rate. States must identify the claims and managed care payments associated with the cases in the monthly sample. States are required to collect payments for services received in the sample month and paid in that month and the following four months plus any adjustments to the collected payments that occur within 60 days of the paid date. The dollar values of the payments associated with all sampled cases (including eligible cases and cases with eligibility errors) will form the basis of the dollar-weighted error rate. States should not conduct a review of the actual payments (e.g., for medical necessity or coding). Rather, States should determine if the beneficiary's eligibility entitled them to the received services.

States must wait five months following the sample month before identifying claims. Claims are identified and associated with a case in accordance with the State's policy on effective date of eligibility. For example, most States provide "full month" coverage in that, if a beneficiary is eligible at any point during the month then the beneficiary's eligibility is effective as of the first day of the month. Other States have "date-specific" eligibility in that eligibility is effective on the date of the Medicaid application or, with CHIP, can be made effective prospectively. For States with date-specific eligibility, collect payments for services received in the first 30 days of eligibility if eligibility begins during the sample month. Cases with prospective eligibility must wait until the case is effective before collecting payment for services received (See **Section 6.2.2**)

Below we provide some examples to illustrate the timeframe for identifying a payment for a case sampled in October.

Example 1: A case sampled in October had a service received on October 15 which was billed by the provider in January and paid by the State on February 15. The claim was later adjusted by the State on April 1. The original payment would be counted in the payment review for the sampled case because the service was received in October (the sample month) and paid in February which is within the five-month window for payment collection. The adjustment would also be considered because it was made on April 1 which is within 60 days of the paid date of February 15.

Example 2: A case sampled in October had a service received on October 15 which was billed by the provider in October and paid by the State on November 15. The claim was later adjusted by the State on December 15. The original payment would be counted in the payment review for the sampled case because the service was received in October (the sample month) and paid in November which is within the five-month window for payment collection. The adjustment would also be considered because it was made on December 15 which is within 60 days of the paid date of November 15.

Example 3: A case sampled in October had a service received on October 15 which was billed by the provider in October and paid by the State on November 15. The claim was later adjusted by the State on March 1. The original payment would be counted in the payment review for the sampled case

because the service was received in October (the sample month) and paid in November which is within the five-month window for payment collection. However, the adjustment would not be considered because it was made on March 1 which is greater than 60 days after the paid date on November 15.

Example 4: A case sampled in October had a service received on October 15 which was billed by the provider in March and paid by the State on April 15. The claim was later adjusted by the State on June 1. The original payment and the adjustment would **not** be counted in the payment review for the sampled case because the service, though received in October (the sample month), was not paid within the five-month window for payment collection.

6.1 – Instructions for Conducting Medicaid and CHIP Payment Reviews

The payment review process, which is identical for Medicaid and CHIP, is described below. For each case, the agency will:

Step 1: Identify services received in the sample month. States with date-specific eligibility should identify services received in the first 30 days of eligibility if eligibility was granted and effective in the sample month.

Step 2: Identify claims and capitation payments for services received. Tally the payment amounts for the services received that are paid in the sample month (or first 30 days of eligibility) and the subsequent 4 months, as applicable. Also see **Section 6.2.2** for how to collect payments for prospective eligibility. The agency must also wait an additional 60 days after the original paid dates to apply adjustments.

Step 3: Verify whether the payments were made appropriately based on the eligibility review findings. The payment review may include determining the beneficiary met his/her liability amount or cost of institutional care, and could result in a **Liability Overstated** or **Liability Understated** error depending on whether the beneficiary underpaid or overpaid towards cost of care. The payment review should also determine whether the beneficiary is eligible for the services received. Payments for services for which the beneficiary is not eligible to receive are considered improper and are included in the error rate calculation.

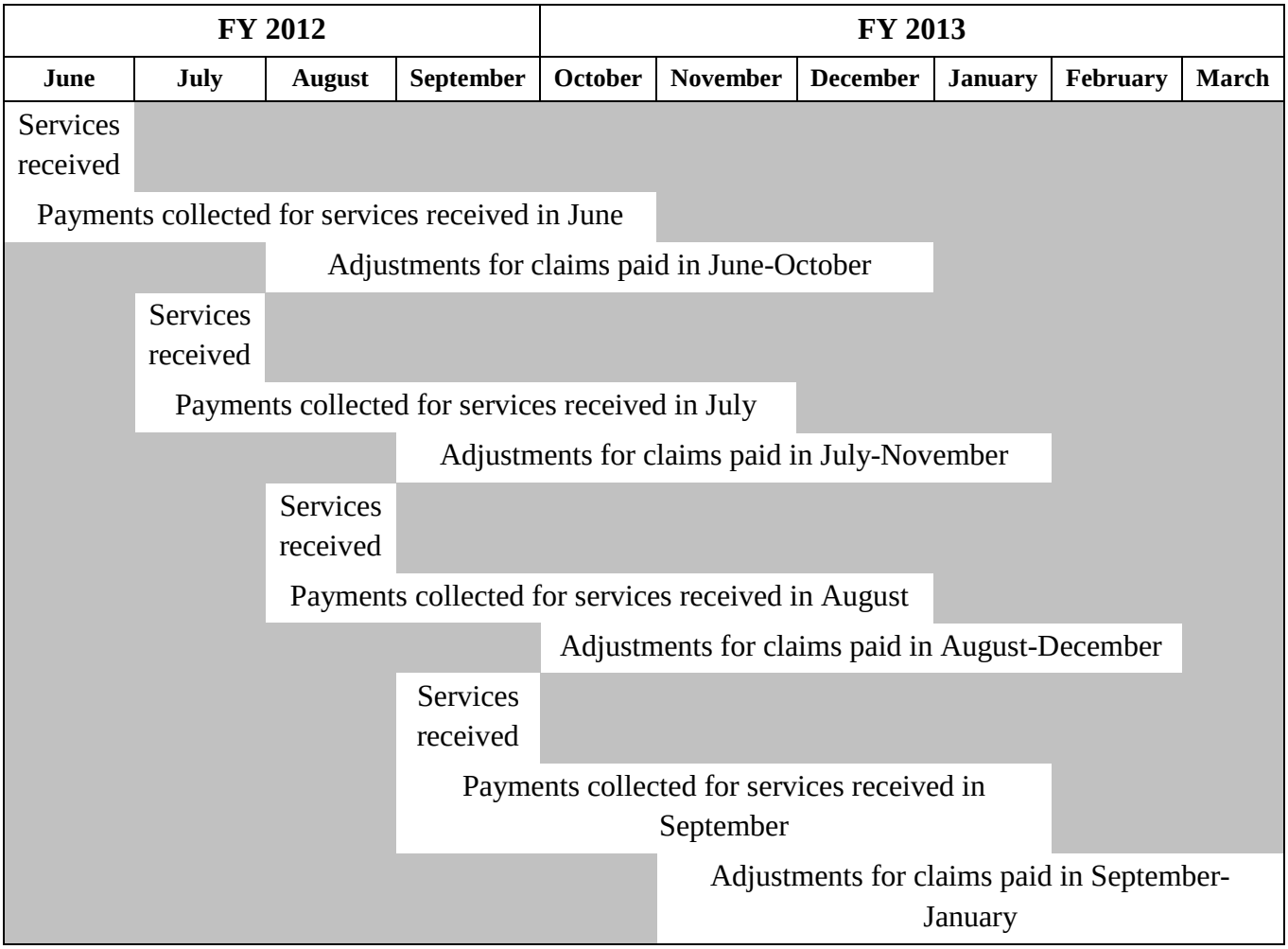
Step 4: Record the amount of correct payments and the amount of dollars in error, if any. States must be able to separately identify overpayments or underpayments in accordance with the eligibility review finding. Note that depending on the results of the payment review, the eligibility review finding could change, e.g., a case is cited **Eligible** for the active case eligibility review, but upon identifying and tallying claims for the payment review, it is discovered that the beneficiary received an uncovered service. The eligibility review finding should be changed to **Eligible with Ineligible Services**, and the total payments paid correctly and the total payments in error must be reported.

Step 5: For **Undetermined** cases where eligibility could not be verified, identify and tally the claims for the services received in the sample month or first 30 days of eligibility as appropriate, and record

the amount for each Undetermined case. Payments identified for cases found to be Undetermined must be reported.

Any adjustments to claims that are the direct result of the eligibility reviews should not be included for the purpose of calculating the eligibility error rate.

Exhibit 6-1: Five-Month Payment Collection Falling Outside the Fiscal Year



6.2 – Other Payment Review Situations

6.2.1 - Payments Made Outside the Fiscal Year

The PERM eligibility reviews measure improper payments for eligibility determinations that occur within the fiscal year. However, due to the lag in time for the PERM payment review process and in order to ensure a complete measurement, payments made outside of the fiscal year should be included in the payment review for services received within the fiscal year (see example in Exhibit 6-2 above).

6.2.2 – Prospective Eligibility

States that grant eligibility prospectively (e.g. Medicaid or CHIP eligibility begins up to 60 days after a determination is made) must wait until the effective date to identify payments for services received in the first 30 days of eligibility. Once eligibility has begun, the State will use the regular time allotments in **Section 6.1** to identify services received and payments made.

6.2.3 – Collection of Capitated Payments

All managed care payments made for coverage in the sample month are included in the review regardless of the actual payment date, so long as the payment dates fall within the five month timeframe. In some States, managed care payments are made to Managed Care Organizations (MCOs) in the month before the month of coverage. Prospective payments for the sample month will be counted.

Employee-Based Health Insurance

Some States make premium payments to an employer for employee-based health insurance when the private health insurance is found to be more cost effective than traditional Medicaid or CHIP coverage. The premium payments are made based on the eligibility of the employed household member. Therefore, the premium payment to an employer for employee-based health insurance should only be collected for the PERM payment review if the employed household member or, in the case the State is sampling at the family unit level, the family unit which includes the employed household member is sampled.

Prorated Capitation Payments

For States with managed care programs that offer date-specific eligibility and pay a pro-rated capitation payment to a MCO, the payment reviews should include the prorated amount of the managed care payment or payments during the first 30 days of eligibility.

Fee-For-Service Carve-Outs

For beneficiaries who are enrolled in managed care, but may also receive services on a fee-for-service basis in which claims are paid in addition to the managed care capitation payment. All payments, managed care and fee-for-service must be included in the eligibility payment review.

6.2.4 – Beneficiary premiums

For cases where an individual or family pay a premium for Medicaid or CHIP coverage to the State, which is then combined with State and Federal funds to pay a managed care organization that provides the coverage, the payment review should consider whether or not the premium payment was calculated correctly to determine whether or not there is a payment error. The difference between what the premium was calculated to be and what the premium should have been would be part of the dollars in error along with any additional payments made on behalf of the individual or family matched with either Title XIX or Title XXI (e.g., capitation payment to a managed care organization). The payment amounts reported should not include the premium amount paid correctly by the individual or family.

Premium Grace Period

There may be some instances where a sampled case did not pay the necessary premium in that month. For Medicaid, States allow beneficiaries a 60 day grace period towards unpaid premiums before terminating eligibility or suspending coverage (§1916(c)(3) of the Act). For CHIP, States must notify

beneficiaries within a certain number of days to pay all premiums in full either before an upcoming redetermination or before terminating eligibility or suspending coverage (42 CFR §457.505(c) and §457.570). If the monthly premium is not paid by the beneficiary in the review month or sample month, review your State plan to determine the time period in which premiums must be paid or penalties for nonpayment of the premium. These would be the basis for improper payments, if any.

CMS released a State Health Official (SHO) letter, **#10-001 CHIPRA Premium Grace Period**, which allows States to give a 30 day grace period at the beginning of the coverage period for a recipient to pay premiums in full, e.g. Coverage period that begins on October 1 must pay premium in full by October 30th before the case can be terminated. **Please review your State Plan to ensure that the appropriate grace period is being applied to the eligibility and payment reviews.**

6.2.5 – Aggregate payments

Aggregate payments should not be included in the payment review process. When a State makes aggregate payments for a program that should be included in the PERM claims universe but the paid amount associated with a specific individual or family cannot be located or separated out from the aggregate amount, the dollars paid on behalf of the individual or family should be omitted from the PERM eligibility payment review.

Section 7 – Agency Conducting Eligibility Reviews and Eligibility Appeals

As stated in the PERM regulations at 42 CFR §431.974(a)(2), personnel responsible for PERM eligibility sampling and review "must be functionally and physically separate from the State agencies and personnel that are responsible for Medicaid and CHIP policy and operations, including eligibility determinations." The intent of this provision was to ensure the independence of the review in order to achieve an unbiased error rate. We provided further clarification that:

- The agency responsible for PERM could be under the same umbrella agency that oversees policy, operations and determinations but the two agencies cannot report to the same supervisor.
- Qualified staff with knowledge of State eligibility policies may be used to conduct the eligibility reviews, but the staff that is chosen must be independent from the staff that oversees policy and operations.
- CMS considers staff to be independent if they temporarily work on PERM eligibility reviews even though they usually work under eligibility policy and operations, so long as the staff does not discuss PERM eligibility reviews with the staff that oversees policy and operations during the time the staff is working on PERM eligibility reviews.

Provided that agency independence could cause a difference in findings between the agency and the State Medicaid and CHIP agencies, appeals for eligibility review findings should be conducted in accordance with the State's existing appeal process.

The State Medicaid or CHIP agencies may document their differences in writing to the agency for consideration. If resolutions of differences occur during the PERM cycle, eligibility findings can be updated to reflect the resolution. If differences are not resolved by the deadline for eligibility findings to be submitted to CMS (July 1), States may continue with appeals after the calculation of the eligibility error rate.

In consideration of States that may not have a State appeals process in place, CMS will allow the Agency to make State findings available to each respective State's Medicaid and CHIP agencies CMS may facilitate documentation exchange between the State Medicaid or CHIP agency and the agency conducting the PERM eligibility reviews to resolve differences.

If any eligibility appeals issues involve Federal policy, States can appeal to CMS for resolution.

Ultimately the State may use an appeals process that already exists at the State level (e.g. for MEQC) or may develop an appeals process specifically for PERM. An eligibility appeals process is not required. All appeals must be documented and the appeal decisions and resolutions must all be documented.

Section 8 – Reporting

States must provide the following information for each program for active and negative cases:

- A Medicaid sampling plan and CHIP sampling plan on August1st prior to the Federal fiscal year in which a State is being measured for PERM
- Before the reviews commence, monthly sample selection lists detailing the active and negative cases selected for review from the previous month's universe and the total number of cases in the active and negative universes
- The detailed eligibility findings for active and negative cases
- The payment review findings on each sampled active case
- By July 1 following the Federal fiscal year, summary eligibility and payment findings for each program. The summary findings may include:
    - State-specific case error data as well as payment error data for active cases
    - State-specific case error data for negative cases
    - The number and payment amounts for Undetermined cases

Please see Appendix A for specific due dates. If the due date falls on a weekend or a Federal or State holiday, the due date is the next business day.

States should submit all findings for each sample month using the PERM Eligibility Tracking Tool (PETT) website and the corresponding report templates. States should also complete the final Summary Report using the data provided on the PETT website and submit the Summary Report to CMS at the end of the cycle. The materials and instructions for using the PETT website will be provided to the States. PETT will serve as a vehicle for States to submit their eligibility reporting forms and allows for a central depository for all State-submitted reports. The PETT has two main purposes:

1. Facilitating the accuracy of State reporting by using an electronic process (e.g., reduces potential for user errors in data entry or copying data files, allows for data to be entered only once); and
2. Providing accurate data for error rate calculation and corrective action analysis. The site will allow data to be easily exported for analysis by State staff.

The website will allow States to either download a form template and upload the completed form back to the website, or fill out the form directly on the website. To upload data, States will input data into the eligibility reporting forms in the Excel template and, following the instructions will upload the data to the PETT website. In order to upload data, States will need to save a copy of the file on a local computer and use the same Excel template throughout the review process (i.e., State will use one Excel template for October, one for November, etc.). For States that choose to input the data directly into the

form, submitted data will be available for review. States that input data directly on the website will also be able to download copies of submitted data for their own records.

Sample forms for PERM are in Appendix J.

Section 9 – Calculating Medicaid and CHIP Eligibility Error Rates

CMS will calculate the eligibility error rates for each program. States may still calculate their own eligibility error rates using the formulas in Appendix I. CMS will provide an error rate calculator for States to use, as well as offer assistance from the statistical contractor to explain State-specific error rates. However, the statistical contractor will calculate the official error rates for each State. A total of three error rates will be calculated for Medicaid and CHIP.

- A payment error rate, which is dollar weighted
- An active case error rate
- A negative case error rate

For informational purposes, States will have the ability to calculate the State error rates two ways:

- Undetermined included as payment errors
- Undetermined excluded as payment errors

Section 10 – PERM Corrective Action Plan (CAP)

Following each measurement cycle, the States included in the measurement are required to complete and submit a Corrective Action Plan (CAP) based on the errors found during the PERM process. CMS provides guidance to State contacts on the CAP 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. Through the CAP process, States are able take administrative actions to reduce errors which cause improper Medicaid and CHIP payments.

Additional guidance will be provided by the PERM CAP Team during the Corrective Action Plan process.

Appendix A: PERM Eligibility Medicaid and CHIP Timeline

PERM Eligibility Timeline for Medicaid and CHIP														
Process			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Pre-Cycle	States submit Sampling Plans– August 1	CMS sampling plan review	States take action to implement approved sampling plans											
Sample Selection				Select October Sample: Due November 15	Select November Sample: Due December 15	Select December Sample: Due January 15	Select January Sample: Due February 15	Select February Sample: Due March 15	Select March Sample: Due April 15	Select April Sample: Due May 15	Select May Sample: Due June 15	Select June Sample: Due July 15	Select July Sample: Due August 15	Select August Sample: Due September 15
Eligibility Review								October Eligibility Review Findings: Due March 31	November Eligibility Review Findings: Due April 30	December Eligibility Review Findings: Due May 31	January Eligibility Review Findings: Due June 30	February Eligibility Review Findings: Due July 31	March Eligibility Review Findings: Due August 30	April Eligibility Review Findings: Due September 31
Payment Review										October Payment Review Findings: Due May 15	November Payment Review Findings: Due June 15	December Payment Review Findings: Due July 15	January Payment Review Findings: Due August 15	February Payment Review Findings: Due September 15
PERM Eligibility Timeline for Medicaid and CHIP--Continued														
Sample Selection			Select September Sample: Due October 15											
Eligibility Review			May Eligibility Review Findings: Due October 31	June Eligibility Review Findings: Due November 30	July Eligibility Review Findings: Due December 31	August Eligibility Review Findings: Due January 31	September Eligibility Review Findings: Due February 28							
Payment Review			March Payment Review Findings: Due October 15	April Payment Review Findings: Due November 15	May Payment Review Findings: Due December 15	June Payment Review Findings: Due January 15	July Payment Review Findings: Due February 15	August Payment Review Findings: Due March 15	September Payment Review Findings: Due April 15					
Post Cycle										States must finalize all eligibility reviews, payment reviews and appeal results.		Finalized Error Findings: Due July 1		

Appendix B: Glossary

Active case: A case containing information on a beneficiary who is enrolled in the Medicaid or CHIP program in the month that eligibility is reviewed.

Active fraud investigation: A beneficiary or a provider has been 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.

Agency: For purposes of the PERM eligibility reviews under this part, the entity that performs the Medicaid and CHIP eligibility reviews under PERM and excludes the State Medicaid or CHIP agency as defined in the regulation.

Annual sample size: The number of eligibility cases necessary to meet precision requirements in a given PERM cycle.

Application: An application form for Medicaid or CHIP benefits deemed complete by the State, with respect to which such State approved or denied eligibility.

Beneficiary: An applicant for, or recipient of, Medicaid or CHIP program benefits.

Beneficiary liability: Either the amount of excess income that must be offset with incurred medical expenses to gain eligibility (spend down) or the amount of payment a beneficiary must make toward the cost of long term care, or in some instances, for home and community-based services.

Case: An individual beneficiary or family enrolled in Medicaid or CHIP or who has been denied enrollment or has been terminated from Medicaid or CHIP.

Case error rate: An error rate that reflects the number of cases in error in the eligibility sample for the active cases or the number of cases in error in the eligibility sample for the negative cases expressed as a percentage of the total number of cases examined in the sample.

Case record: Either a hardcopy or electronic file that contains information on a beneficiary regarding program eligibility.

Children's Health Insurance Program (CHIP): Program authorized and funded under Title XXI of the Act.

CHIP universe: Cases where all services are paid with Title XXI funds, including Title XXI Medicaid expansion cases that are funded under CHIP.

Eligible: Meeting the State's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs.

Improper payment: Any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible recipient, any duplicate payment, any payment for services not received, any payment incorrectly denied, and any payment that does not account for credits or applicable discounts.

Last action: The most recent date on which the State agency took action to grant, deny or terminate program benefits based on the State agency's eligibility determination; and is the point in time for the PERM eligibility reviews unless the last action occurred outside of 12 months prior to the sample month.

Medicaid: A joint Federal and State program authorized and funded under Title XIX of the Social Security Act.

Medicaid universe: Cases where all services are paid with Title XIX funds.

Negative case: A case containing information on a beneficiary who applied for benefits and was denied or whose program benefits were terminated based on the State agency's eligibility determination.

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. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulations or policy.

Payment Error 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.

PERM: The Payment Error Rate Measurement process to measure improper payments in Medicaid and CHIP.

Payment review: The process by which payments made for services are associated with cases reviewed for eligibility. Payments are collected for services received in the review month, the first 30 days of eligibility or the sample month, depending on the case and stratum being reviewed.

Retroactive eligibility: When an applicant is eligible for Medicaid in any or all of the three months prior to the month of application (e.g. an applicant applies in April and eligibility is effective beginning in January.

Review month: The month in which eligibility is reviewed (usually when the State took its last action to grant or redetermine eligibility). If the State's last action was taken more than 12 months prior to the sample month, the review month shall be the sample month, unless otherwise specified in these instructions.

Sample month: The month the State selects a case from the sampling universe for an eligibility review.

State agency: The State agency that is responsible for determining program eligibility for Medicaid and CHIP, as applicable, based on applications and redeterminations.

State error: Includes, but is not limited to, eligibility errors as described in 42 CFR §431.960(b) and (d) of the PERM Final Rule, as determined in accordance with documented State or Federal policies or both.

Technical error: Errors identified during the eligibility review that would not result in a difference between the amount that was paid and the amount that should have been paid (i.e., an improper payment) as described in **Section 5.5**.

Undetermined: A beneficiary case subject to a Medicaid or CHIP eligibility review under PERM about which a definitive eligibility review decision could not be made.

Appendix C: Sampling Plan Template Outline

Eligibility Sampling Plan for [State] Program: [Medicaid or CHIP] Fiscal Year [Year] Independent Entity [Agency]
Sampling Plan Contact List the contact information, including name, email address, and telephone number, for State Medicaid or CHIP individual who will serve as the main contact for answering questions related to the sampling plan.
Agency Independence: The State should identify the agency and personnel or contracting entity responsible for eligibility reviews in its sampling plan with a stated assurance that the agency is independent of the State agency responsible for policies, operations and eligibility determinations and enrollment or that the contracting entity is independent of the State's eligibility and enrollment activities. Please indicate any of the following circumstances that are applicable to your State: (1) That the agency responsible for PERM is under the same umbrella agency that oversees policy, operations and determinations but the two agencies do not report to the same supervisor; (2) That qualified staff with knowledge of State eligibility policies is used to conduct the eligibility reviews, but the staff that is chosen is independent from the staff that oversees policy and operations; or (3) The staff is considered to be independent because they temporarily work on PERM eligibility reviews even though they usually work under eligibility policy and operations, and that staff is barred from discussing PERM eligibility reviews with the staff that oversees policy and operations during the time the staff is working on PERM eligibility reviews.

State Medicaid and/or CHIP agency:

List and describe the agencies in the State that make eligibility determinations. Note that this may also be information that the Agency may want to record during the review process for corrective action purposes.

Eligibility Appeals Process:

Describe the eligibility appeals process which will be employed by the State.

Eligibility Appeals Contacts:

List the contact information for State Medicaid and CHIP personnel that will be involved in State-level eligibility appeals. If no appeals process exists at the State level, these will serve as contacts for CMS to facilitate documentation exchange between the Agency and State Medicaid and CHIP agency.

Self-Declaration States:

Indicate whether or not your State has self-declaration policies and under what circumstances self-declaration is acceptable. This includes States that conduct ex-parte reviews, passive renewal redeterminations or other simplified enrollment processes.

Description of MEQC Activities for the Current Fiscal Year

Give a brief description of proposed or approved MEQC activities beginning (or continuing) in the upcoming fiscal year.

Indicate if the State is administering a "traditional" MEQC review, or give a short description of the State's pilot program. Indicate whether or not the State has an MEQC pilot that is included as part of a waiver under Section 1115 of the Social Security Act.

If administering a "traditional" MEQC review, indicate whether or not the State is substituting MEQC data to fulfill the requirements of the PERM eligibility review, or indicate if the State is using the PERM eligibility reviews to fulfill the requirements of MEQC.

Data Systems

Describe the systems eligibility from which the data is pulled. Ensure that all systems, especially if data is pulled from multiple systems, are listed here.

Active Cases

1. Description of the Universe for active cases.

2. Indicate the sampling unit selected. 3. Indicate if the State has implemented Express Lane Eligibility and an estimate of the number of beneficiaries enrolled using Express Lane Eligibility as of the date of the sampling plan.
4. Description of the strata for active cases (if applicable).
5. Description of the following: • How the monthly sample will be drawn; • How cases will be selected including the method used to randomly select cases; • The number of cases that will be oversampled to account for fraud cases or other cases inappropriately included in the sample.
6. The quality control procedures that will be applied including procedures to ensure completeness of the population from which the sample is drawn.
7. Description of how records or claims and managed care payments associated with the cases sampled will be obtained.
8. Projected monthly sample size for each stratum (if applicable).
9. A description, and underlying assumptions, regarding how the sample size was determined. If the sample size deviates from that recommended in this instruction due to the application of a finite population correction (i.e., the State's universe for the previous fiscal year is less than 10,000), a detailed explanation is required of how the alternative sample size was estimated and why it is likely to achieve precision requirements. Sample sizes that are less than the recommended sample size must be approved by CMS, i.e., finite population, prior to implementation. If the sample size (whether it increases or decreases) is based on the eligibility payment error rate from the previous PERM cycle, indicate that here.
Negative Cases 1. Description of the universe for negative cases.
2. Description of how the monthly sample will be drawn, the random method used to select cases, and the quality control procedures that will be applied.
3. Projected monthly sample size

4. A description, and underlying assumptions, regarding how the sample size was determined. If the sample size deviates from that recommended in this instruction due to the finite population correction, a detailed explanation of how the alternative sample size was estimated and why it is likely to achieve precision requirements is required. Sample sizes that are less than the recommended sample size due to the finite population correction (i.e., the State's universe for the previous fiscal year is less than 10,000) must be approved by CMS, based on the information in the sampling plan, prior to implementation. If the sample size (whether it increases or decreases) is based on the eligibility payment error rate from the previous PERM cycle, indicate that here.

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Appendix D: PERM Eligibility Stratification

Stratification Overview

The PERM regulation, published on August 11, 2010 gives States the option to choose whether or not to stratify the active case universe for eligibility sampling purposes. While many States will opt not to stratify, we understand that some States may want to continue to stratify for reasons such as maintaining previously developed programming or in order to have more easily accessible case information. Therefore, we have provided below the policies and procedures for stratifying the active case universe for those States that opt to continue with this approach.

Stratification Sampling

All policies regarding the sampling timeframe, the overall sample size, the method for selecting the random sample, and the timing of drawing and submitting the sample in this guidance should be followed. Sampling variations for States that are stratifying include:

- Each State must always sample an equal number of applications, redeterminations and all other cases each month.
- States will need to identify universe totals for each month for each of the three strata.

Stratification Assignment

The active case universe needs to be broken down into three strata, from each of which a random sample will be selected. The three strata are:

- **Stratum one (new applications)**: A case should be placed in stratum one in either the month that the State took an action to grant eligibility or in the month that a newly approved application becomes effective, whichever is later.
    - **Note**: States should count an individual reapplying for Medicaid or CHIP after a break in eligibility as a new application and place the case in stratum one. A break in coverage may occur when the case is properly closed by the State and a client loses coverage, files a new application, and the case is reopened. For example, a case is properly closed based on caseworker or system action and reopened in a later month, retroactively back to the first of the month, based on new information provided by the client.
- **Stratum two (redeterminations)**: A case should be placed in stratum two in either the month that the State took an action to continue eligibility or in the month that a new eligibility period begins, whichever is later.

- **Stratum three (all other cases)**: All other cases (properly included in the universe but do not meet the strata one or two criteria) that are on the program in the sample month are placed in stratum three.

Assigning active cases to either stratum one – new applications or stratum two – redeterminations should be based on the decision month or the effective month, whichever is later. The decision month is the month when a State makes a decision to grant or continue eligibility to a beneficiary after an application or redetermination is complete. The effective month is the month when the beneficiary becomes eligible to receive Medicaid or CHIP services. States should **not** include a case in stratum one or stratum two in any month prior to when the decision to grant or continue eligibility was made (see examples below). Cases in stratum three should be sampled for each month in which the beneficiary is receiving Medicaid or CHIP coverage and is not a new application or redetermination in that month.

> **Example 1**: In State A, a person applies for Medicaid coverage on January 20. The State makes a decision on January 30 that the person is eligible. State A grants full month coverage to beneficiaries, therefore coverage for this person begins on January 1. The decision month and the effective month are the same and this case would be placed in stratum one universe in January.
>
> **Example 2**: In State B, a person applies for Medicaid coverage on January 20. The State makes a decision on January 30 that the person is eligible, including for a period of retroactive coverage beginning November 1. The decision month would be January and the effective month would be November. Since PERM eligibility does not consider the retroactive eligibility period, this case would be in stratum one in January, as the decision month is later than the effective month.
>
> **Example 3**: In State C, a Medicaid eligible beneficiary has a redetermination in January. A decision is made in January to grant eligibility for another year, beginning on February 1. The decision month is January and the eligibility effective month is February. Therefore this case should be placed into stratum two in the February sample.

In addition to the overall stratification criteria outlined above, there are some additional specific circumstances which States may have to consider when assigning cases to a stratum, as follows:

- **Continuous eligibility cases**: After being included in stratum one in the initial month that eligibility becomes effective or the decision to grant eligibility is made (whichever is later), these cases should be in the stratum three universe for the remainder of the continuous eligibility period; include continuous cases in stratum two in the month the 12-month redetermination becomes effective.
- **September sample**: States should only include cases in their September universe for stratum one and stratum two cases that have an effective date in September. Cases approved or redetermined for coverage in September for eligibility beginning in October should **not** be included in the September sampling universe.

- **Example**: A State decides on September 15 to grant eligibility to an individual for a coverage period beginning October 1; this case should not be included in the September sampling universe and therefore would not be sampled in the fiscal year.

- **SSI conversion cases**: The State should place SSI conversion cases in Stratum 3 until the State redetermines eligibility and should place SSI conversion cases in Stratum 2 in the month when the redetermination becomes effective.
  - If these cases are found to be ineligible for continued Medicaid coverage, they should go into the negative universe in the month the termination decision is effective.
  - States should note that, for SSI conversion cases, Federal regulations at 42 CFR §435.1003 limits Federal financial participation to the end of the month in which SSA notifies the State of the loss of SSI (if received before the 10th of the month) or until the end of the next month (if notification is received after the 10th of the month) and requires a "prompt redetermination of eligibility".

Spend Down

Depending on how each State captures spend down case information, there may be a different method for how to address them in the PERM universes. If a spend down case is selected, the case will be reviewed to ensure the accuracy of the spend down amount and that expenses used toward spend down were appropriately allowed and calculated correctly. These cases may have no payment dollars collected if no services received in the sample month were matched with Title XIX dollars.

Denials: For States that capture spend down cases as denials due to excess income, these cases would be included in the negative case universe either monthly or at the six month redetermination (if eligibility is denied due to spend down not being met).

Pending: For States that capture spend down cases as pending applications, these cases would not be included in the active or negative case universes due to the case actions for these cases being incomplete.

Active without receiving benefits: For States that capture spend down cases as active cases that are not receiving benefits, states should include the case in the active universe for sampling and review according the guidelines presented in Section 5.

For the PERM review, review the most recent action to grant eligibility or redetermine eligibility and determine that the expenses used toward spend down were appropriately allowed and calculated correctly.

Retroactive Eligibility

Retroactive eligibility is when an applicant is eligible for Medicaid in any or all of the three months prior to the month of application (e.g., an applicant applies in April where the eligibility is effective beginning in January). Whether a State grants date-specific eligibility or full month eligibility, the

three month retroactive period should not be considered for sampling purposes and is not included for eligibility review or payment collection review purposes. See the chart below that illustrates why the 3-month retroactive period in Medicaid would not fall into the universe of cases for the April sample month.

Retroactive Cases Not Included in Universe

	January	**February**	**March**	**April**	**May**
Beneficiary A: Example of date-specific eligibility	First month of three month retroactive period	Second month of three month retroactive period	Third month of three month retroactive period	Person applies for Medicaid. State decides person is eligible and puts on eligibility rolls effective April 21	Ongoing coverage
When case appears in universe	Not in sampling universe; no payments collected	Not in sampling universe; no payments collected	Not in sampling universe; no payments collected	In Stratum 1 sampling universe; payments collected if sampled	In Stratum 3 sampling universe; payments collected if sampled
Beneficiary B: Example of full month eligibility	First month of three month retroactive period	Second month of three month retroactive period	Third month of three month retroactive period	Person applies for Medicaid. State decides person is eligible and puts on rolls effective April 1	Ongoing coverage
When case appears in universe	Not in sampling universe; no payments collected	Not in sampling universe; not payments collected	Not in sampling universe; no payments collected	In Stratum 1 sampling universe; payments collected if sampled	In Stratum 3 sampling universe; payments collected if sampled

Review of Stratified Cases

Once the review month is identified, States should primarily refer to the review guidelines referenced in **Section 5**.

- For stratum one cases, the review month is the month in which a decision was made to grant eligibility.
    - **Example 1**: The State samples a case in June in stratum one with a decision date of May 25; the review month would be May and the State would review the new application.
- For stratum two cases, the review month is the month in which a decision was made to extend eligibility coverage.
    - **Example 2**: The State samples a case in June in stratum two with a decision date of May 25; the State would review the redetermination decision that occurred in May.
- For cases in stratum three, the review month is the month of the State's last action and is different from the sample month.
    - **Example 3**: The State samples a case in June in stratum three and the last action taken on the case was in January; the review month would be January and eligibility would be verified based on the decision made in January.
- The exception to verifying eligibility as of the review month is when the State's last action for a stratum three case occurred more than 12 months prior to the sample month; in that instance, eligibility for the case is verified as of the sample month.

Payment Collection for Stratified Cases

For cases in strata one and two, the agency will identify payments for services received in the sample month or the first 30 days of eligibility, depending upon whether the State grants full month or date-specific eligibility. Payments for cases in stratum three are identified as of the sample month. Only include payments for services received in the sample month or the first 30 days of eligibility (if applicable) and paid in that month and in the four following months(because submission and payment of a claim lags behind the date of service). In addition, all adjustments that occur within 60 days of the payment date should be included with the claim. Any adjustments to claims that are the direct result of the eligibility reviews should not be included for the purposes of calculating the eligibility error rate. States should follow all other payment guidelines, as provided in **Section 6**.

Other Payment Collection Situations

Managed care capitation payments:

All managed care payments made for coverage in the review month for strata one and two cases or in the sample month for stratum three are included regardless of the actual payment date so long as the payment dates fall within the five month timeframe. In some States, managed care payments are made

to managed care organizations in the month before the month of coverage. Prospective payments for the sample month will be included.

Appendix E: Lost or Destroyed Eligibility Documentation Policy

The PERM eligibility review involves the review of eligibility case records, including eligibility worker notes, hard copy case records and other sources, that provide information to review the eligibility status of selected cases. The Medicaid agency may be unable to obtain necessary documents due to loss from a natural disaster. In the event that an eligibility review cannot be completed due to such losses, the affected State will be allowed to drop the sampled case and replace it with an oversample case.

Excluding a Case with Lost or Destroyed Documentation

If a State is not able to locate a record due to it being lost or destroyed in a FEMA declared disaster please provide the following to CMS[8]:

- Case ID number
- Whether the case record was lost or destroyed (completely or partially[9])
- Approximate date the loss occurred
- Indicate that the record was lost or destroyed by[10]:
    - Flood
    - Fire
    - Hurricane
    - Other

Many states receive §1115 waivers as part of disaster recovery efforts. A reference to the State's approved waiver should be included in the approximate date of the loss. If a lost or destroyed case record is later located or can be built to complete a review, the review finding must be submitted.

[8] This information can be provided via secure email as long as the Case ID number is randomly assigned and does not include PII.
[9] For partial documentation, there must be an attempt to complete the review.
[10] Note these must be FEMA declared disasters. Lost or destroyed records included in this policy do not include loss due to agency error.

Appendix F: Active and Negative Case Eligibility Sample Size

This appendix elaborates on the theory of sample sizes at the State-level for the dollar-weighted active case error rates. Note that the formulas require States to identify the number of strata. Depending on whether or not a State chooses to stratify the active case universe, the number of strata will be either 12 (one stratum per month for the 12-month cycle) or 36 (three strata per month for the 12-month cycle).

Eligibility Sample Size Calculation

The error rate estimate is given by

$$\hat{R} = \frac{\sum_i w_i \sum_j e_{ij}}{P}$$

where, e_{ij} = error for the j-th observation in the i-th stratum

P = total payments

w_i = weight for the i-th stratum = N_i/n_i (where N_i is the Universe total for i-th strata and n_i is the sample size for the i-th strata).

For the eligibility category,

$$e_{ij} = \begin{cases} P_{ij} \\ 0 \end{cases}$$

depending on if the (i,j)-th observation is ineligible/eligible (can also be termed as "in error"/ "not in error").

$$\text{Let,} \quad X_{ij} = \begin{cases} 1 \quad ; \quad \text{with prob } \pi_i \\ 0 \quad ; \text{with prob } 1 - \pi_i \end{cases}$$

where, X_{ij} = 1 when the j-th observation for i-th strata is "in error"/ineligible for the payment

π_i = chance an observation in the i-th stratum is "in error".

Then, the error rate can alternatively be written as,

$$\hat{R} = \frac{\sum_i w_i \sum_j X_{ij} P_{ij}}{P}$$

The variance of is given by,

$$Var(\hat{R}) = \frac{\sum_i w_i^2 Var\left(\sum_j X_{ij} P_{ij}\right)}{P^2}$$

Assume,

$$E\left(P_{ij}\right) = \mu_{P_i}$$
$$Var(P_{ij}) = \sigma_{P_i}^2$$

Now,

$$Var\left(\sum_j X_{ij} P_{ij}\right) = Var\left(E\left(\sum_j X_{ij} P_{ij} \middle| X_{ij}\right)\right) + E\left(Var\left(\sum_j X_{ij} P_{ij} \middle| X_{ij}\right)\right)$$

$$= Var\left(\sum_j X_{ij} \mu_{P_i}\right) + E\left(\sum_j X_{ij}^2 \sigma_{P_i}^2\right)$$

$$= \mu_{P_i}^2 \sum_j Var(X_{ij}) + \sigma_{P_i}^2 \sum E\left(X_{ij}^2\right)$$

$$= \mu_{P_i}^2 n_i \sigma_{X_i}^2 + \sigma_{P_i}^2 n_i \left(\sigma_{X_i}^2 + \mu_{X_i}^2\right)$$

$$= n_i \left(\mu_{P_i}^2 \sigma_{X_i}^2 + \sigma_{P_i}^2 \sigma_{X_i}^2 + \sigma_{P_i}^2 \mu_{X_i}^2\right)$$

Then,

$$Var(\hat{R}) = \frac{\sum_i w_i^2 Var\left(\sum_j X_{ij} P_{ij}\right)}{P^2}$$

$$= \frac{\sum_i \frac{N_i^2}{n_i^2} n_i \overbrace{\left(\mu_{P_i}^2 \sigma_{X_i}^2 + \sigma_{P_i}^2 \sigma_{X_i}^2 + \sigma_{P_i}^2 \mu_{X_i}^2\right)}^{\xi_i}}{P^2}$$

By Neyman-Pearson optimal allocation,

$$n_i = \frac{P_{i\cdot}}{\sum_i P_{i\cdot}} n$$

where, $P_{i\cdot}$ = Total payments for the *i*-th stratum ($\sum_i P_{i\cdot} = P$)

n = Total sample size (sum of all strata - unknown)

Hence, the variance for $\hat{R}$ can be further reduced as,

$$Var(\hat{R}) = \frac{\sum_i \frac{N_i^2 P}{P_{i\cdot} n} \xi_i}{P^2} \text{ (substituting for } n_i\text{)}$$

$$= \frac{1}{nP} \sum_i \frac{N_i^2}{P_{i\cdot}} \xi_i \ = \sigma_{\hat{R}}^2$$

The $(1-\alpha)100$ percent confidence interval for the error rate, *R*, is given by,

$$\hat{R} - z_{\alpha/2}\sigma_{\hat{R}} \le R \le \hat{R} + z_{\alpha/2}\sigma_{\hat{R}}$$

The margin of error, *d*, is thus

$$d = z_{\alpha/2}\sigma_{\hat{R}}$$

$$\Rightarrow d^2 = z_{\alpha/2}^2 \sigma_{\hat{R}}^2$$

$$= z_{\alpha/2}^2 \frac{1}{nP} \sum_i \frac{N_i^2}{P_{i\cdot}} \xi_i$$

Hence the total sample size, *n*, is given by

$$n = \frac{z_{\alpha/2}^2}{d^2} \frac{1}{P} \sum_i \frac{N_i^2}{P_{i\cdot}} \xi_i$$

To get an estimate for the sample size, it is important to have estimates for ξ_i, which requires knowledge of variance for payments in each stratum ($\sigma_{P_i}^2$), the chance of belonging to a stratum (π_i, since $\mu_{X_i} = \pi_i$ and $\sigma_{X_i}^2 = \pi_i(1-\pi_i)$) (note that for the study, chance of belonging to a stratum is equivalent to the error rate for the stratum). However, in reality, this is not known, but we know that

stratification reduces the variance. Hence, if we ignore stratification and consider a simple random sample, the variance of the ratio estimator then computed would be higher.
Considering all the factors discussed above and to keep computation simple, we use the formula for a simple random sample, even if doing so would give an overestimate for the sample size.

For a simple random sample, the sample size, n, is given by

$$n = \frac{z_{\alpha/2}^2}{d^2}\frac{N^2}{P^2}\xi = \frac{z_{\alpha/2}^2}{d^2}\frac{1}{\overline{P}^2}\xi$$

where, $\xi = \mu_P^2\sigma_X^2 + \sigma_P^2\sigma_X^2 + \sigma_P^2\mu_X^2$ (calculations for these formula could be done in the same way as the derivation shown in case of stratified sampling – simply consider $i = 1$).

Let the coefficient of variation (C.V) for payment be

$$K = \frac{\sigma_P}{\mu_P}$$

$$\text{Then, } \xi = \mu_P^2\sigma_X^2 + \sigma_P^2\sigma_X^2 + \sigma_P^2\mu_X^2$$

$$= \mu_P^2\sigma_X^2 + K^2\mu_P^2\sigma_X^2 + K^2\mu_P^2\mu_X^2$$

$$= \mu_P^2\left(\sigma_X^2 + K^2\sigma_X^2 + K^2\mu_X^2\right)$$

$$= \mu_P^2\left(\left(1+K^2\right)\sigma_X^2 + K^2\mu_X^2\right)$$

For a simple random sample,

$$X\begin{cases}1; & \text{w.p.}\,\pi\\ 0; & \text{w.p.}\,1-\pi\end{cases}$$

(π can also be interpreted as the error rate).

Hence,

$$\xi = \mu_P^2\left(\left(1+K^2\right)\pi(1-\pi) + K^2\pi^2\right)$$

Note: An estimate for μ_P is, $\hat{\mu}_P = \overline{P}$.

Hence, for a simple random sample

$$n = \frac{z_{\alpha/2}^2}{d^2}\frac{N^2}{P^2}\xi = \frac{z_{\alpha/2}^2}{d^2}\frac{1}{\overline{P}^2}\xi$$

$$= \frac{z_{\alpha/2}^2}{d^2}\frac{1}{\overline{P}^2}\mu_P^2\left(\left(1+K^2\right)\pi(1-\pi)+K^2\pi^2\right)$$

$$= \frac{z_{\alpha/2}^2}{d^2}\left(\left(1+K^2\right)\pi(1-\pi)+K^2\pi^2\right)(\text{substituting } \hat{\mu}_P = \overline{P})$$

For IPIA requirement, to construct a 95 percent confidence interval for the error rate

~ α = 0.05

~ d = 0.03 (3.0 percentage points)

Note: Study on previous data (on PERM) shows that the coefficient of variation for payments is generally less than or equal 1 for all States.

Finite Population Correction Factor

Formula to determine sample size based on FPC

$$n' = n\frac{N}{N+n-1}$$

Where *n* is the original sample size (504) and *N* is the population size.

The sample size should be estimated to obtain a precision level of 3 percentage points at the 95 percent confidence level for the active case payment error rate. To determine the sample size required to estimate the active case payment error rate (at the State level) with a specified precision, the following equation is used:

Formula to determine sample size to meet required confidence and precision

$$n = \frac{z_{\alpha/2}^2}{d^2}\left(\left(1+K^2\right)\pi(1-\pi)+K^2\pi^2\right)$$

and

$$n_i = \frac{P_{i\cdot}}{\sum_i P_{i\cdot}}n$$

Where *n* is the total sample size, n_i is the sample size for each stratum, *i* is the stratum (likely to be active case type and month), *K* is the coefficient of variation for payments (assumed to be constant across strata), π is the probability a case's eligibility is incorrect, *z* is the standard normal value, *a* is the level of significance, and *d* is the desired precision.

It is important to note in the sampling process how many cases to sample from each of the three active case strata each month. Standard sampling theory would suggest sampling in proportion to the number of dollars represented in the stratum. However, because Stratum 3 clearly contains the majority of payments, this rule would lead to a large sampling of beneficiaries from this stratum. Therefore, in the absence of this information regarding the variation in errors or payments across strata, an equal number of cases will be drawn from each of the three strata each month over a twelve month period.

State-level precision for 95 percent confidence interval for the error rate is achieved by setting the following:

- $a = 0.05$
- $d = 0.03$ (3.0 percentage points)
- $k = 1.00$

Appendix G: MEQC & PERM Sampling and Review Differences

Provision	"Traditional" MEQC	PERM
Administrative Period	MEQC provides an administrative period that consists of the review month and the month prior to the review month. The administrative period provides a reasonable period of time to reflect changes in a case.	No administrative period necessary. PERM reviews cases as of the last action and information should be current.
Client Contact	Home visits for client interviews.	Not always necessary to contact beneficiary if case record has all information to make a review decision.
Error Dollar Tolerance	Liability errors less than $5 are not counted. The lesser of the amount of excess resources or the amount of Medicaid payment. Round to the nearest dollars. Highest error amount from all errors identified in a case is one that prevails.	No tolerance for errors.
Error Rate Calculation	All States must remain below National Standard of 3% to avoid disallowances. Lower limit confidence interval used to calculate Medicaid payment error rate and compare to National Standard.	Mid-point of the confidence interval is used.

Provision	"Traditional" MEQC	PERM
Exclusions	**From the active case universe:** • Those cases for which Medicaid eligibility was determined by SSA in 1634 contract States; • Cases eligible for Medicaid based on title IV-E adoption, guardianship assistance or foster care; • Cases funded 100 percent by the Federal Government for Medicaid and CHIP; • Retroactively eligible cases; and • Cases that have been approved for Medicaid or CHIP using the States' "Express Lane" eligibility option according to Section 1902(e)(13) and Section 2107(e) of the Social Security Act. **From review:** • Beneficiary does not cooperate; • Beneficiary cannot be located; • Beneficiary moved out of State; or • Beneficiary has requested an appeal of an eligibility determination.	**From the active case universe:** • All cases that were denied or terminated; • Cases under active fraud investigation as defined in Appendix B; • State-only funded cases for which the State receives no Federal matching dollars; • Cases that have been approved for Medicaid or CHIP using the States' "Express Lane" eligibility option according to Section 1902(e)(13) and Section 2107(e) of the Social Security Act; • For Medicaid only, Supplemental Security Income (SSI) cash cases in States with an agreement with the Social Security Administration (SSA) under Section 1634 of the Social Security Act; and • For Medicaid only, adoption assistance and foster care cases under Title IV-E. **From review:** None

Provision	"Traditional" MEQC	PERM
Incomplete Reviews	**Cases can be dropped from review if:** • Client cannot be located; • Client does not respond to requests for information; or • Client has moved out of State.	Information not retrieved for the PERM review could result in an "Undetermined" finding.
Precision	95% confidence with +/- 2% precision	95% confidence with +/- 3% precision
Recovery of Improper Payments	Disallowance provision of §1903(u) of the Social Security Act apply for States with improper payments over the 3% National Standard.	Disallowance provisions of Section 1903(u) of the Act for Medicaid eligibility improper payments. Disallowance provisions under Section 2105(e) of the Act apply for CHIP eligibility improper payments.
Review Month	Review month and sample month are the same.	Review month is the date of last action on a case, up to 12 months prior to sample month. Review month is sample month if last action was more than 12 months prior to sample month.
Sample Size	Varies by State: Minimum sample sizes for each State in MEQC manual.	Base year sample size is 504 active cases. Can be reduced or increased in future cycles based on the variance and standard error of the error rate calculated in the State's previous cycle.
Sampling Unit	Assistance unit; Family unit; "case"	Individual beneficiary or family.
Source of Errors	MEQC identifies Agency errors vs. Client errors	PERM considers all eligibility errors State errors.

Provision	**"Traditional" MEQC**	**PERM**
Stratification	Prior to 1996, States stratified Medicaid Only cases and AFDC-Medicaid cases. Post 1996, this stratification no longer required due to the separation of AFDC and Medicaid. States without a Section 1634 agreement with The Social Security Administration should stratify Medicaid cases and SSI cash cases, unless waived with CMS approval.	Stratification is optional. Cases are stratified by (1) applications, (2) redeterminations and (3) all other cases.

Provision	"Traditional" MEQC	PERM
Required Verification	Independently verify actual circumstances. Client interviews and home visits required.	States are required to review the case record and independently verify eligibility criteria where evidence is missing, or outdated and likely to change, or otherwise as needed. An applicant's self declaration statement for Medicaid or CHIP would be acceptable verification for eligibility where State policy allows for self-declaration, so long as the following requirements are met. The self-declaration statement must be: • Present in the record; • Not outdated (more than 12 months old); • In a valid, State approved format; and • Consistent with other facts in the case record. Additionally, if the above requirements are not met, a State may verify eligibility through a new self-declaration statement if permitted under State law or policy, and, if a new self-declaration cannot be obtained, the State may verify eligibility using third party sources, for example, documentation listed in section 7269 of the State Medicaid Manual. If none of these efforts to verify the self-declaration are successful, then the case should be cited as "Undetermined."

Appendix H: PERM-MEQC Data Substitution

The PERM regulations at 42 CFR §431.812(f) and 42 CFR §431.980(f) allows States in their PERM year the option to apply PERM data to meet the annual MEQC requirements or apply "traditional" MEQC data to meet the PERM eligibility component requirements. It should be noted that a State does not have to be a "traditional" MEQC State to employ one of the substitution options, but it must be understood that a State must choose to use the "traditional" MEQC methodology **or** have the understanding that the use of the PERM review methodology will constitute a "traditional" MEQC review. Below are the conditions that must be met in order to employ one of the substitution options.

Develop a Sampling Plan

States must submit the most current MEQC "traditional" sampling plan with all applicable elements listed in Section 7130 of the State Medicaid Manual (SMM). If a State does not have a current "traditional" sampling plan (e.g. due to the State conducting pilots for more than 1 year), submit the following information:

- Sampling unit selected (individual beneficiary or family (assistance) unit)
- Description of the universe of sampling units
- Systems from where the universes are being pulled
- Size of the universe
- Method of selection, e.g. random number generator, random number table, systematic random sample, etc.

Each State will work with the statistical contractor to develop a modified sampling plan that will include a suitable sample size up to 1,000 active cases for Medicaid and/or CHIP (if Medicaid Expansion). The sample size must be a sufficient size to meet PERM precision requirements and PERM and MEQC universe and sample requirements. Note that the sample size may vary from the base year PERM sample size of 504 active cases, and may also vary from the standard sample sizes for each State listed in the State Medicaid Manual Part 7, Chapter 2, Exhibit 1.

PERM stratification is optional. The three PERM strata are as follows:

Stratum One: Applications—the State took action to grant eligibility in the month or a newly approved application becomes effective, whichever date is later.

Stratum Two: Redeterminations—the State took action to continue eligibility in the month or a new eligibility period begins, whichever is later.

Stratum Three: All Other Cases—Cases that are on the program in the month, but have not had an application or redetermination.

If a State chooses to stratify, each month States must sample using the decision date or the effective date, whichever is later. For more information on PERM eligibility stratification, see **Appendix D: PERM Eligibility Sampling Stratification** in the eligibility review guidance.

Review Requirements

Once the State has chosen which program (MEQC or PERM) it would like to apply, the program that the State chooses is the standard that will be used for all sampled cases that apply to that program.

States using PERM should review each case as of the last action. States using MEQC will review each case as of the sample month (review month) and apply the administrative period.

Substituting MEQC reviews

Review all cases in accordance to the modified review methodology under *Modified MEQC Review Requirements*. Upon review of each case, use the most appropriate PERM eligibility review finding:

Finding	Definition
E	Eligible
EI	Eligible with Ineligible Services
NE	Not Eligible
L/O	Liability Overstated
L/U	Liability Understated
MCE1	Ineligible for Managed Care
MCE2	Eligible for Managed Care, but improperly enrolled
U	Undetermined

Complete the payment review process as described in the Eligibility Review Guidance at **Section 6-Payment Reviews of Active Medicaid and CHIP Cases**.

Modified MEQC Review Requirements

Considering the vast differences between the "traditional" MEQC review process and the revised PERM eligibility review process under the August 2010 final rule, we have developed modified MEQC review requirements to assist with the ease of the PERM review and acknowledging State resource concerns. Please note that if your State is substituting MEQC reviews to meet the PERM requirements that the modified review requirements must be used to maintain consistency with other States that are using this option.

The Modified MEQC review includes:

1. **Case Record Review**

A case record is defined as either a hard copy or electronic file that contains information on a beneficiary regarding program eligibility. The case record could include copies of official documents, written caseworker notes and worksheets (e.g. initial application, verification checklist), electronic documents pulled from other sources, electronic case notes from the eligibility worker documenting

their actions, etc. Analyze the case record to identify gaps in required documentation or deficient information in the review month based on missing documentation or misapplied State and Federal policy.

2. Field Investigation

Once the case record review is complete and deficiencies have been identified, conduct a field investigation to re-verify and document the eligibility elements found deficient. The field investigation should encompass all actions taken to resolve deficiencies or to apply the correct State and Federal policy to determine if the case circumstances are correct. The reviewer may complete a client interview if it will assist in verifying deficiencies that may be based on misapplied State and Federal policy. Interviews with collateral contacts and notes from these telephone conversations are also acceptable verification in order to make a review decision. Home visits are not required.

3. Assign Error Findings

Each MEQC review that will be applied to the PERM findings must have a PERM eligibility review decision assigned to it. Depending on the MEQC finding for each case, assign the most appropriate PERM error finding code.

Section 7230 of the State Medicaid Manual (SMM) lists acceptable reasons for States not to complete an MEQC review on a case. The acceptable reasons for States to drop a case from the MEQC review are as follows:

- Beneficiary does not cooperate
- Beneficiary cannot be located
- Beneficiary moved out of State
- Beneficiary has requested an appeal of an eligibility determination

MEQC cases that are dropped from review due to these reasons listed must be reported for PERM purposes. The reason for the drop must be included in the reporting of these findings. These cases will be considered **Undetermined** for PERM purposes unless the case can be completed using other reasonable evidence. Upon error rate calculation, the undetermined case will be included in the PERM error rate calculation and excluded from the MEQC error rate calculation.

Substituting PERM Reviews

Review each case in accordance with the PERM eligibility review guidance and assign each case the appropriate PERM finding. The use of the PERM reviews will serve as a “traditional” MEQC review.

The CMS Central Office and each State’s CMS Regional Office will coordinate to monitor State progress.

The August 2007 PERM final rule made effective the option for States to use PERM negative case reviews to comply with the negative MEQC case action review requirements. The process for using the PERM negative case reviews to complete the MEQC negative case action reviews will remain the

same. A State does not have to substitute active case data to use this option. Please see the Eligibility Review Guidance at **Section 4.3-Negative Case Sample.**

PERM & MEQC Payment Reviews

The process for completing the PERM and MEQC payment reviews remain the same, but one main caveat: States using the MEQC review process may not apply an error dollar tolerance to their payment reviews.

States will wait five months following the sample month before identifying claims for services received in the sample month. Claims for services received in the sample month are identified and associated with a case in accordance with the States' policy on effective date of eligibility, either full month or date-specific eligibility. See the chart below that exhibits an example of the payment review process. The example illustrates the timeframe for identifying a payment for a service received by a case sampled in October. Based on the eligibility review finding, verify whether the identified payments were made appropriately. Report the correct payments, improper payments and payments associated with undetermined cases for each sample month.

PERM Payment Review Process Example

October	November	December	January	February	March	April
Service Received	-	-	Service Billed by Provider	Service Paid by State	-	Payment Adjusted by State

For the general step-by-step process to complete the eligibility payment reviews, including specific payment review situations, please see **Section 6—Payment Reviews of Active Medicaid and CHIP Cases**.

Error Rate Calculation

Upon completion of the eligibility and payment reviews, States will compile and report their summary findings and the PERM statistical contractor will calculate each State's error rate for PERM and MEQC. The PERM error rate is calculated using the midpoint estimate of the confidence interval and include undetermined cases. The MEQC error rate is calculated using the lower limit of the confidence interval.

Please note that the substitution options do not encompass CHIP Stand-alone programs. States with CHIP Stand-alone may only substitute Medicaid data. The CHIP PERM measurement remains separate. States with Title XXI Medicaid expansion programs may use their MEQC reviews to complete the PERM eligibility review requirements. Title XXI Medicaid expansion data must be separated from the MEQC Medicaid data to calculate a PERM CHIP error rate.

If a State chooses to substitute PERM or MEQC data, the State may not dispute error findings or the eligibility error rate based on the possibility that findings would not have been in error had the other review methodology been used.

Administrative Funding

States that choose to substitute MEQC data may only claim the regular administrative matching rate for performing the MEQC procedures for Medicaid and Title XXI Medicaid expansion cases. The 90 percent PERM enhanced administrative matching rate will only be applicable to States conducting PERM reviews for CHIP cases.

Reporting

The CMS Central Office and CMS Regional Offices will work in conjunction to ensure reporting requirements are met and corrective actions are developed and implemented. All findings for PERM and MEQC will be submitted to the eligibility review tracking website in accordance with the PERM timeline.

Appendix I: Calculating Medicaid and CHIP Eligibility Error Rates

Calculating the Active Case Payment Error Rates

The active case sample includes a specified number of cases each month for each of the three strata. The method of estimating the error rate is called the combined ratio estimator. The payment amounts and amounts of payments in error associated with a case consists of all the fee-for-service claims incurred by the case with a date of service in the sample month, the review month or the first 30 days of eligibility, as appropriate, and that were paid through that month and the following four-month period. Managed care payments consist of all managed care payments made on behalf of the case for coverage of services in the applicable month the case was sampled. The basic strategy of the combined ratio estimator is to estimate total errors and total payments based on the sample information. The sampling frequencies are used to project errors and payments observed in the sample of the State population values. This strategy, then, provides appropriate payments to combine the errors across each of the three strata into a single error rate for the universe.

Note that the formulas require States to identify the number of strata. Depending on whether or not a State chooses to stratify the active case universe, the number of strata will be either 12 (one stratum per month for the 12 month cycle) or 36 (three strata per month for the 12 month cycle).

The payment error rate for the combined ratio estimator is given by

$$\hat{R} = f(\hat{t}_e, \hat{t}_p) = \frac{\hat{t}_e}{\hat{t}_p} = \frac{\sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} e_{kl}}{\sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} p_{kl}}$$

Where

$$\hat{t}_e = \sum_{k=1}^{a} \frac{M_k}{m_k} \sum_{l=1}^{m_k} e_{kl} = \sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} e_{kl}$$

$$\hat{t}_p = \sum_{k=1}^{a} \frac{M_k}{m_k} \sum_{l=1}^{m_k} p_{kl} = \sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} p_{kl}$$

m_k is the number of cases sampled from stratum k,

M_k is the number of cases in the universe from stratum k,

e_{kl} represents the dollar value of error on the lth case in the kth stratum,

p_{kl} represents the payment on the lth case in the kth stratum, and

"*a*" represents the number of strata; for actives (3 strata x 12 months = 36 strata).

Alternatively, using the same combined ratio estimator, we could consider three components to the error rate, one for each of the case types. For example,

$$E_S = \sum_{i=1}^{12} \frac{M_{S,i}}{m_{S,i}} \sum_{j=1}^{m_{S,i}} e_{S.i,\mathrm{j}}$$

And

$$P_S = \sum_{i=1}^{12} \frac{M_{S,i}}{m_{S,i}} \sum_{j=1}^{m_{S,i}} p_{S.i,j}$$

where

S is the major case stratum type (*S*=1 [application], *S*=2[redetermination], *S*=3[all other]),

E_s are the total projected errors from major strata *S*, and

P_s are the total projected payments from major strata *S*.

Then,

$$\hat{R} = \frac{E_1 + E_2 + E_3}{P_1 + P_2 + P_3} = f(\hat{t}_e, \hat{t}_p) = \frac{\hat{t}_e}{\hat{t}_p} = \frac{\sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} e_{kl}}{\sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} p_{kl}}$$

The sample of cases is drawn over a twelve month period.

Then, estimated variance is given by

$$\hat{Var}(\hat{R}) = \frac{1}{\hat{t}_p^2} \sum_{k=1}^{a} W_k^2 n_k \hat{Var}(e_{kl} - \hat{R} p_{kl}) = \frac{1}{\hat{t}_p^2} \sum_{k=1}^{a} W_k^2 n_k \left(\frac{\sum_{l=1}^{n_i} (e_{kl} - \hat{R} p_{kl} - (\bar{e}_k - \hat{R} \bar{p}_k))^2}{n_k - 1} \right)$$

A 95 percent confidence interval is constructed around the point estimate of the active case payment error rate as

$$\text{Confidence Interval} = \hat{R} \pm 1.96 \sqrt{\hat{Var}(\hat{R})}$$

Calculating Active and Negative Case Error Rates

For the active and negative case error rates, the errors are not dollar weighted. However, the combined error rate estimator is repeated here, with changes made because the two case error rates will have no dollar weights associated with them.

The error rate for the combined ratio estimator for the case error rate is given by

$$\hat{R} = f(\hat{t}_e, \hat{t}_p) = \frac{\hat{t}_e}{\hat{t}_p} = \frac{\sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} e_{kl}}{\sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} p_{kl}}$$

Where

$$\hat{t}_e = \sum_{k=1}^{a} \frac{M_k}{m_k} \sum_{l=1}^{m_k} e_{kl} = \sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} e_{kl}$$

$$\hat{t}_p = \sum_{k=1}^{a} \frac{M_k}{m_k} \sum_{l=1}^{m_k} p_{kl} = \sum_{k=1}^{a} W_k \sum_{l=1}^{m_k} p_{kl}$$

m_k is the number of cases sampled from stratum k;

M_k is the number of cases in the universe from stratum k;

e_{kl} is a 1 if the l-th case in the k-th stratum is in error, 0 otherwise;

p_{kl} is a 1 for the l-th case in the k-th stratum; and

"a" represents the number of strata; for actives there are 36 strata and for negatives, 1 stratum.

The variance is exactly the same as the variance for the combined ratio estimator given in the previous section.

Note: If one were to ignore the strata and assume that all cases over the year are drawn from the same population and that sampling by month was merely an administrative convenience, a simpler estimator could be applied. In this instance, we are estimating a sample proportion. The point estimate of the error rate is

$$\hat{\Pi} = \frac{\sum_{i=1}^{m} q_i}{m}$$

Where

$\hat{\Pi}$ is the estimated error rate;

q_i is equal to 1 if the sampled case, i, is in error and equal to 0 if sampled case was correctly determined; and

m is the sample size.

The sampling variance of this estimator is

$$\hat{Var}(\hat{\Pi}) = \frac{\hat{\Pi}(1-\hat{\Pi})}{m}$$

A 95 percent confidence interval around the point estimate is given by

$$\text{Confidence Interval } = \hat{\Pi} \pm 1.96\sqrt{\hat{Var}(\hat{\Pi})}$$

Appendix J: Reporting Forms

Payment Error Rate Measurement (PERM) Eligibility Review Findings Form Example

A: State											
B: Date											
C: Program											
D: Sample Month											
E: Active Universe Total											
E1: Stratum 1 Universe Total (if applicable)											
E2: Stratum 2 Universe Total (if applicable)											
E3: Stratum 3 Universe Total (if applicable)											
F: Negative Universe Total											
Case/ Beneficiary ID	**Eligibility Category**	**Universe**	**Stratum (if applicable)**	**Case Action**	**Review Month**	**Review Finding**	**Total Dollars**	**Total Dollars in Error**	**Total Dollars Correct**	**Total Dollars Undetermined**	**Cause of Error**
1.											
2.											
3.											
4.											
5.											

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1012.

INSTRUCTIONS FOR COMPLETING THE PERM ELIGIBILITY REVIEWS
PERM ELIGIBILITY REVIEW FINDINGS

- **Line A: State**

  The name of the State is pre-populated on the form.

- **Line B: Date**

  The current date is pre-populated on the form.

- **Line C: Program**

  The program (Medicaid or CHIP) is pre-populated on the form.

- **Line D: Sample Month and Year**

  The sample month and year is pre-populated on the form.

- **Line E: Active Universe Total**

  The Active Universe is the total number of cases in the sample month that are considered eligible for services based on a completed application, redetermination or are currently on the program rolls. The universe will be unique for each month.

  If the State is stratifying active cases, complete E.1, E.2, and E.3.

  Enter the total number of active cases during the sample month. For active cases, include the number of cases in each stratum in the respective cell as follows:

  - **E.1 - Stratum One total** – Enter the total number of Stratum 1 cases during the sample month. A case is in Stratum 1, "Application," in the month the decision is made to grant eligibility or in the month the eligibility becomes effective, whichever is later.
  - **E.2 - Stratum Two total** – Enter the total number of Stratum 2 cases during the sample month. A case is in Stratum 2, "Redetermination," in the month the decision is made to continue eligibility or in the month the new period of eligibility becomes effective, whichever is later.
  - **E.3 - Stratum Three total** – Enter the total number of Stratum 3 cases during the sample month. A case is in Stratum 3, "All Other Cases" if the case is on the program in the sample month but does not meet the Strata 1 or 2 criteria.

- **Line F: Negative Universe Total**

  The Negative Universe is comprised of all cases denied in the sample month and all cases where the termination is effective in the sample month. The universe will be unique for each month.

- **Case ID**

  Enter the case identification (ID) or beneficiary ID, whichever is the custom of the State that correlates with the case reported as sampled on the monthly sample selection for the sample month.

This column should include the ID numbers for active and negative cases. Depending on a State's administration of the eligibility reviews, cases could be assigned a "review number" or "dummy ID" and not the random case or beneficiary ID. If the State chooses this option for submitting dummy ID numbers, the case ID numbers that correspond to the dummy ID numbers should be sent to CMS via secure email or a password-protected CD.

- **Eligibility Category**

  The eligibility category is the eligibility coverage program in which the beneficiary is enrolled under Medicaid or CHIP. This information can be completed when you submit the Eligibility Review Report and is not required for Negative Universe cases. For each case, select the appropriate eligibility category from the drop-down list. The Eligibility Category options are provided below.

  If the sampled individual is enrolled in more than one category, choose what the state believes is the "primary" category. Note that the "primary" category will not necessarily be based on dollars associated with the case, but instead could be based on the category requested at application.

  Example: An individual is enrolled in QMB and Nursing Home Medicaid. Nursing Home is the primary because the applicant is in need of nursing care at the time of application, and is at that time also found eligible for QMB. In this example, QMB is considered the secondary category.

  States are also provided an "Other" category if none of the descriptions apply to a sampled case, e.g. a State has a CMS approved waiver and the waiver category does not fit one of the PERM categories.

  - Families with Dependent Children (General)
  - Caretaker Relative - Categorically Needy
  - Caretaker Relative - Medically Needy
  - Children (All Ages) less than 133% Federal Poverty Limit
  - Children (All Ages) Medically Needy
  - Pregnant Woman
  - Newborn
  - Unborn Child (Undocumented Pregnant Woman)
  - Transitional Medicaid
  - Aged, Blind & Disabled Categorically Needy
  - Aged, Blind & Disabled Medically Needy
  - SSI Recipients (Non-1634 States)
  - Institutional or Hospital Care
  - QMB
  - SLMB
  - Qualifying Individual
  - Qualified Disabled and Working Individuals
  - Other Full Benefit Dual Eligible (FBDE)
  - Home and Community-Based Services
  - Katie Beckett
  - Nursing Home
  - Elderly Waivers
  - Family Planning Services
  - Women with Breast or Cervical Cancer
  - Emergency Services (Including for Non-Citizens)
  - Medicaid expansion
  - CHIP Stand-alone

- Other (None of the Above)

- **Universe**

  For each case, select Active or Negative universe.

- **Stratum (only complete if stratifying)**

  For each case, Select Stratum 1 (Applications, Stratum (Redeterminations), or Stratum 3 (All Other Cases).

- **Case Action**

  Identify the last case action on the case. For Active Cases, enter Application if the action on the case was to grant eligibility based on a completed application or Redetermination if the action on the case was to redetermine eligibility based on a completed redetermination. (**NOTE**: When submitting data directly into the PETT website, States that stratify will only have to enter this information for Stratum Three cases; Stratum One and Stratum Two cases are pre-populated on the form based on the data provided in the Stratum field). For Negative Cases, states should select Denial if the action being reviewed is the denial of a new application or Termination if the action being reviewed is termination based on a redetermination of eligibility.

- **Review Month**

  Enter the review month for which eligibility was verified (the review month is not necessarily the same as the sample month). In general, the review month is the month of the last action. If the last action was more than 12 months prior to the sample month, the review month is the sample month. For Stratum 1 (Applications) and Stratum 2 (Redeterminations) cases, the review month should be the same as the sample month if the decision and effective dates are in the same month. For Negative Universe cases, the review month would be the month a case was denied or terminated.

- **Review Finding**

  Select the letter code for the review finding (e.g., E, NE, IE, MCE1) for each case. The active and negative case review finding codes are defined as follows:

Active Cases

- **E - Eligible –**A case meets the State's categorical and financial criteria for receipt of benefits under the program.
- **NE - Not eligible** – An individual beneficiary or family is receiving benefits under the program but does not meet the State's categorical and financial criteria being verified using the State's documented policy and procedures.
- **EI - Eligible with ineligible services** – An individual beneficiary or family meets the State's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP program but was not eligible to receive particular services in accordance with the State's documented policies and procedures.

- **U - Undetermined -** The case record lacks or contains insufficient documentation, in accordance with the State's documented policies and procedures, to make a definitive review decision for eligibility or ineligibility.
- **L/O - Liability overstated –** The beneficiary overpaid toward an assigned liability amount or cost of institutional care and the State underpaid.
- **L/U - Liability understated** – The beneficiary underpaid toward an assigned liability amount or cost of institutional care and the State overpaid.
- **MCE1 - Managed care error, Ineligible for managed care** –- Upon verification of residency and program eligibility, the beneficiary is enrolled in managed care but is not eligible for managed care.
- **MCE2 - Managed care error, Eligible for managed care but improperly enrolled** — Beneficiary is eligible for both the program and for managed care but not enrolled in the correct managed care plan as of the month eligibility is being verified.
- **X – Dropped** – Case is dropped from the sample. Sampling situations that might cause a State to adjust the sample and the universe after it has already been pulled include when:
    - A case is found to be under active beneficiary fraud investigation;
    - A case should have been excluded from the sampling universe but was included inadvertently in the universe and sampled (e.g., a State-only case was sampled); or
    - A case was enrolled in Medicaid or CHIP using States' Express Lane Eligibility option, set forth in Section 1902(e)(13) and Section 2107(e)(1) of the Social Security Act (although these cases should be coded in a way that they could be excluded from the sampling universe).

Note: If a case is identified in the sample under the above conditions, or other circumstances not listed here that may warrant a drop, please contact CMS and the SC before making a resubmission. This will help CMS identify the scope of any sampling concerns and provide the appropriate guidance for how to proceed.

Negative Cases

- **C - Correct** – The negative case was properly denied or terminated by the State.
- **ID - Improper denial** – An application for program benefits was denied by the State for not meeting a categorical and/or financial eligibility requirement but, upon review, is found to be eligible for the tested category or a different category under the program in accordance with the State's documented policies and procedures.
- **IT - Improper termination** – During a redetermination, the State determined that an existing beneficiary no longer met the program's categorical and/or financial eligibility requirements and was terminated but upon review is found to have been eligible for the tested category or a different category under the program in accordance with the State's documented policies and procedures.

- **X - Dropped** – Case is dropped from the sample. Please contact CMS and the SC when a case needs to be dropped.

- **Cause of Error**

  Enter the cause of the error for findings other than Eligible or Correct. For each error, select the appropriate cause of error from the drop-down list. The Cause of Error options are provided below.

  For cases that are found to have more than one cause of error, CMS leaves discretion to the States to identify the primary cause of error. For cases where more than one aspect of eligibility cannot be verified, the State should select "Eligibility Criteria Cannot be Verified.

  The list of PERM error causes is not all-inclusive. If cases are in error based on agency or client circumstances that are not listed here, States may select one of the "Other" error causes.

Active Case Options	
Income: Client Failed to Report Countable Income	Citizenship/Identification/Residency: Case Record Missing Citizenship/Identity Doc
Income: Agency Failed to Collect Appropriate Income Verification	Citizenship/Identification/Residency: Agency Failed to Accept Appropriate Citizenship/Identification Doc
Income: Agency Miscalculated Countable Income	Citizenship/Identification/Residency: Residency Cannot be Determined
Income: Other	Citizenship/Identification/Residency: Recipient is Not a State Resident
Assets: Agency Failed to Accept Appropriate Asset Verification	Citizenship/Identification/Residency: Other
Assets: Agency Miscalculated Countable Assets	State Procedure: Application is Incomplete
Assets: Client Failed to Report Countable Assets	State Procedure: Missing/Insufficient/Inconsistent Case Notes
Assets: Other	State Procedure: Missing Pregnancy Verification (Eligibility/Technical Error)
Household Composition: Person Improperly Included/Excluded from Budget Group	State Procedure: Beneficiary Premium Payment Miscalculated
Household Composition: Agency Accepted Inappropriate Verification of Household Composition	State Procedure: Recipient in Wrong Medicaid Category
Household Composition: Other	State Procedure: CHIP Case not Properly Screed for Medicaid Eligibility

Third Party Liability (TPL): Client Failed to Report TPL	State Procedure: Agency Failed to Accept Appropriate Self Declaration
Third Party Liability (TPL): TPL Failed to Pay Applicable Medical Expenses	State Procedure: Other
Third Party Liability (TPL): Client Ineligible Due to TPL	Eligibility Criteria Cannot be Verified
Third Party Liability (TPL): Other	

Negative Case Options	
Recipient Not Given 10 Day Advance Notice	Case Not Evaluated for Transitional Medicaid/Medicaid Extension
Notice had Incorrect Denial/Termination Reason	Case Terminated Without Evaluation for Other Medicaid Category
Missing Case Record	Other
Agency Failed to Act on Timely Verification	

- **Total Dollars**

  For Active Universe cases only, enter the total dollars for claims paid for services received in the sample month by each case.

- **Total Dollars in Error**

  For Active Universe cases only, enter the amount of payment that is in error based on each case's:

  - Ineligibility for services received;
  - Ineligibility for the program;
  - Liability overstated or understated;
  - Ineligibility for managed care; or
  - Eligibility for managed care but enrollment in the wrong managed care plan (e.g., the difference in the amount managed care capitation payment for which the case is eligible, if any).

  Enter the portion of the total payments, in whole or in part, that was in error for each sampled case. Place a zero in this column if there is no payment amount in error.

- **Total Dollars Correct**

  For Active Universe cases only, a correct payment amount is a payment to a provider, insurer or managed care organization based on the case's eligibility for the program and for the services received under the coverage group under which the case is eligible as defined in the State's plan.

  - For fee-for-service cases, enter the total amount of dollars paid for the beneficiary based on claims for services received at any time through the sample month and paid in that month or the four subsequent months, allowing 60 days for adjustments.
  - For managed care cases, enter the capitated amount paid for the case. All managed care payments for the sample month are included regardless of the actual payment date so long as the payment dates fall within the sample month and are paid by the end of the fourth subsequent month after the sample month. Prospective capitation payments are also included in the payment review so long as the prospective payment is applied to the beneficiary's coverage in the sample month.

  Enter the portion of the payments, in whole or in part, as appropriate, that were correct for each sampled case. Place a zero in this column if there is no correct payment amount.

- **Total Dollars Undetermined**

  For Active Universe cases only, enter the amount of payments that are undetermined based on a case not having the verification necessary to make an eligibility review decision. The total payment amount for an undetermined case must be placed in this column. Place a zero in this column if the case is not undetermined. **Do not make any entry to the Total Dollars column.**

Leave payment columns blank if a case is dropped and leave payment columns blank for all negative cases.

Payment Error Rate Measurement (PERM) Eligibility Reviews
Summary Findings

A. State										
B. Date										
C. Program										
	Number of Cases in Universe	**Number of Cases Sampled**	**Number of Cases Dropped from Sample**	**Number of Cases Correct**	**Number of Cases Incorrect**	**Number of Cases Undetermined**	**Total Dollars Paid**	**Total Dollars Correct**	**Total Dollars in Error**	**Total Dollars Undetermined**
D. Active										
Stratum 1 (if applicable)										
Stratum 2 (if applicable)										
Stratum 3 (if applicable)										
E. Negatives										
Denials										
Terminations										
F. Totals										

I certify that this information is accurate and that the State will maintain the sampled case records used in the calculation of the eligibility error rate for a minimum period of three years from this date. I understand that this information may be subject to Federal review and that our sampled case records are subject to Federal audit.

Signature: _____ Date: _____

State Medicaid or CHIP Director or Designee

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1012.

INSTRUCTIONS FOR COMPLETING THE PERM ELIGIBILITY REVIEWS SUMMARY FINDINGS

Purpose: The Summary Findings form provides summary case review information from the review of all cases in the monthly active and negative case samples as well as the payment error data, as appropriate. This form provides comprehensive data for active cases (total and for each of the three strata, if applicable) and negative cases (total denials and terminations).

This form is due by July 1st following the fiscal year being measured (i.e., for States completing PERM eligibility reviews for fiscal year 2010, the summary report is due July 1st, 2011).

Line By Line Instructions

SUMMARY FINDINGS TABLE

Line A: State

Enter the name of the State participating in the PERM program that is submitting this report. "State" refers to the 50 States and the District of Columba. The Territories are excluded from the PERM program.

Line B: Date

Enter the date the Summary Findings form is being submitted to CMS (e.g., July 1, 2010).

Line C: Program

Enter the program for which the Summary Findings form applies (e.g., Medicaid or CHIP).

Line D: Active

Enter the total number of active cases. An active case is a case containing information on beneficiaries who are enrolled in the Medicaid or CHIP program in the sample month. (Note: If stratifying, provide the total number of cases in each stratum.)

Line E: Negative

A negative case is a case containing information on a beneficiary who applied for benefits and was denied or whose program benefits were terminated based on the State agency's eligibility determination.

Enter the total number of negative cases; equal to the sum of denials and terminations.

Denials—Denials occur when the State rejects an application for not meeting categorical and financial eligibility requirements.

Enter the total number of denials sampled for the year.

Terminations—Terminations occur when an existing beneficiary no longer meets eligibility requirements and the State took an action to terminate program eligibility.

Enter the total number of terminations sampled for the fiscal year.

Line F: Totals

Enter the total number of cases in each column. For example, in column one, enter the total number of cases in the universe. In column two, enter the total number of cases sampled in each stratum (if applicable) of the active cases and total number of cases sampled as denied and terminated for negative cases. In column three, enter the number of cases dropped during the fiscal year based on the acceptable reasons to drop a case, etc.

For each row, enter the appropriate numbers in each column as follows:

- **Number of Cases in the Universe column**: Enter the number of cases in the universe subject to sampling for the months reviewed throughout the fiscal year. These cells should be left blank in the Denials and Terminations rows because this information is not collected.
- **Number of Cases Sampled column**: Enter the number of cases sampled in each of the categories described in the rows (when applicable, e.g., include the total number of active cases if the State did not stratify the cases into the three eligibility strata).
- **Number of Cases Dropped from Sample**: Enter the number of cases excluded from the sample due to the acceptable reasons given in the PERM eligibility guidance in each of the categories described in the rows. These should equal the number of dropped cases reported on the monthly PERM Eligibility Review Findings form.
- **Number of Cases Correct column**: Enter the number of cases deemed to be correct through the PERM eligibility reviews in each of the categories described in the rows (when applicable, e.g., include the total number of correct active cases if the State did not stratify the cases into the three eligibility strata).

  These should equal the number of cases reported on the PERM Eligibility Review Findings forms completed throughout the fiscal year with findings for E-eligible, EI-eligible with ineligible services, L/O-liability overstated, L/U-liability understated, MCE1-managed care error, ineligible for managed care, or MCE2-eligible for managed care, but improperly enrolled.

  Include the number of denied and terminated cases found correct (coded C for cases correctly denied and terminated) through the negative case action reviews throughout the fiscal year as reported on the PERM Eligibility Review Findings forms.

- **Number of Cases Incorrect column**: Enter the number of cases deemed to be incorrect through the PERM eligibility review in each of the categories described in the rows (when applicable, e.g., include the total number of incorrect active cases if the State did not stratify the cases into the three eligibility strata).

  These should equal the number of cases reported on the PERM Eligibility Review Findings forms completed throughout the fiscal year with a finding of NE-not eligible.

  Include the number of denied and terminated cases found incorrect through the negative case action reviews throughout the fiscal year as reported on the PERM Eligibility Review Findings forms (coded ID for improper denial and IT for improper termination).

- **Number of Cases Undetermined column**: Enter the number of cases for which the State was unable to determine eligibility in each of the categories described in the rows (when applicable).

  These should equal the number of cases reported on the PERM Eligibility Review Findings forms completed throughout the fiscal year with findings of U-Undetermined.

  The cells should be left blank in the Negative, Denials and Terminations rows because Undetermined review findings do not apply to negative cases.

- **Total Dollars Paid column**: Enter the total dollars paid that corresponds with each of the categories described in the rows.

  The cells should be left blank in the Negative, Denials and Terminations rows because payment reviews are not completed for negative cases.

- **Total Dollars Correct column**: Enter the total dollars paid correctly that corresponds with each of the categories described in the rows (when applicable).

  The cells should be left blank in the Negatives, Denials and Terminations rows because payment reviews are not completed for negative case.

- **Total Dollars in Error column**: Enter the total dollars paid in error that corresponds with each of the categories described in the rows (when applicable).

  The cells should be left blank in the Negatives, Denials and Terminations rows because payment reviews are not completed for negative cases.

- **Total Dollars Undetermined column**: Enter the total dollars associated with all cases cited as Undetermined and corresponds with each of the categories described in the rows (when applicable).

  The cells should be left blank in the Negative, Denials and Terminations rows because payment reviews are not completed for negative cases and undetermined cases are not associated with negative cases.

Appendix K: Changes to PERM Eligibility Component due to CHIPRA Legislation and PERM Final Rule

Topic	Previous Policy	New Policy	Notes
Error Rate Calculation	-	FY 2007 and FY 2008 States have the option to accept or reject their CHIP error rates from the FY 2007 and FY 2008 cycles.	Further clarification on the process by which States could choose to accept or reject their error rates for these cycles can be found in the SHO letter released with the rule.
Sample Size	Each State had the same sample size for each component of the measurement.	Beginning in FY 2011, State-specific sample sizes will be calculated based on the year's component-level error rates.	CMS' statistical contractor will calculate each State's sample size for each component.
Sample Size	No maximum sample size	The maximum sample size is set at 1,000 Medicaid or CHIP claims, 1,000 active Medicaid or CHIP cases, and 1,000 negative Medicaid or CHIP cases.	Because reviewing claims requires both staff and monetary resources, a maximum sample size puts a limit on expenditures. Statistical tests suggest that if State-level precision cannot be met with a sample size of 1,000, it is unlikely to be met with any reasonable sample size, but increasing the sample size to up to 1,000 increases the likelihood that precision could be met.

Topic	Previous Policy	New Policy	Notes
Universe	-	Express Lane Eligibility cases should be excluded from the sampling universe for the eligibility component.	CHIPRA sets forth the policy for excluding cases subject to the Express Lane Eligibility process. These cases will be reviewed in a separate improper payments measurement outside of PERM and MEQC.
Error Determinations	No distinction between types of errors.	The regulation distinguishes between State or provider errors.	Data processing and eligibility review errors are categorized as State errors and medical review errors as provider errors.
Self Declaration	States were required to verify items that were self declared.	States can accept current self declaration documentation in the case file.	-
Difference Resolution	No eligibility appeals process	States may use their own eligibility appeals process if one exists, or develop one specifically for PERM. Regulation encourages coordination between agency administering PERM eligibility reviews and State Medicaid agency. CMS will assist in facilitating an eligibility appeals process upon request and will resolve appeals based on Federal policy.	-

Topic	Previous Policy	New Policy	Notes
PERM/MEQC Harmonization	-	CHIPRA allows States to use traditional MEQC to replace PERM in a State's given PERM cycle. The regulation allows States to use PERM to replace MEQC.	CMS has revised the Eligibility Review Guidance to reflect this policy change.
Sampling Unit	"Case" was defined as an individual beneficiary.	"Case" is now defined as an individual or family.	States can use either definition. Universe totals will need to reflect the sampling unit used by the State.
Error Rate Calculation	States were required to calculate their eligibility error rates.	The statistical contractor will calculate eligibility error rates.	States will be required to sign off and submit summary findings data by July 1 after the close of their cycle.
Universe	Active cases must be stratified into the three strata: Applications, Redeterminations, All Other Cases.	States have the option to stratify or not stratify active cases.	Policy change based on comments.
Corrective Action Plans (CAP)	No CAP guidance documented in regulation.	States will be required to submit and implement corrective action plans no later than 90 days from the date the State's error rate is posted to the CMS contractor's website.	Policy change regarding the 90 days (changed from 60 days) based on comments.