

# Payment Error Rate Measurement (PERM)

---

*Verifying Eligibility for Medicaid and CHIP Benefits*

## Table of Contents

Section 1 - Introduction .....	4
Section 2 - Eligibility Overview .....	7
Section 3 – Sampling .....	8
3-1 - Active Case Sample .....	9
3-1-1 - Identifying the Active Case Universe .....	9
3-1-2 - Sampling Stratified Active Cases .....	10
3-1-3 - Stratifying Active Cases .....	12
3-1-4 - Stratifying Active Cases—Additional sampling situations .....	13
3-1-5 - Sample Size for Active Cases .....	14
3-1-6 Method for Drawing the Monthly Sample .....	16
3-1-7 - States Substituting MEQC Data.....	19
3-2 - Negative Case Sample.....	20
3-2-1 - Identifying the Negative Case Universe .....	20
3-2-2 - Sampling the Negative Case Universe.....	20
3-2-3 - Sample Size for Negative Cases .....	20
3-2-4 - Method for Drawing the Monthly Sample.....	20
3-2-5 - Substituting Negative Findings.....	22
Section 4 Eligibility Reviews of Active Cases .....	22
4-1 - Review Month .....	23
4-2 - Verification Standards.....	24
4-2-1 – Required PERM Verification .....	24
4-2-2 - Acceptable Documentation.....	25
4-2-3 - Acceptable Self Declaration .....	26
4-2-4 - Self Declaration for Medicaid.....	26
4-2-5 - Self Declaration for CHIP.....	27
4-2-6 - Simplified Enrollment and Passive Renewal for Applications and Redeterminations.....	28
4-3 - PERM Technical Errors .....	28

4-4 - Process for Conducting Medicaid and CHIP Active Case Reviews: Other Review Situations.....	29
4-4-1 - Presumptive Eligibility .....	29
4-4-2 - Continuous Eligibility .....	30
4-4-3 - SSI Conversion Cases .....	30
4-5 - Process for Verifying Active Case Eligibility .....	30
4-6 - Process for Conducting Medicaid and CHIP Negative Case Reviews .....	33
Section 5 Payment Reviews of Active Medicaid and CHIP Cases .....	34
5-1 - Other Payment Collection Situations .....	37
5-2 - Instructions for Conducting Medicaid and CHIP Payment Reviews.....	38
Section 6 Reporting.....	40
6-1 - Sampling Plan .....	42
6-2 - Monthly Sample Selections.....	43
6-3 - Detailed Active and Negative Case Review Findings .....	43
6-4 - Active Case Payment Review Findings .....	43
6-5 - Medicaid and CHIP Summary Findings and Error Data.....	43
Section 7 Calculating Medicaid and CHIP Eligibility Error Rates.....	44
Appendix A: Eligibility Review Process Timeline.....	45
Appendix B: Glossary.....	47
Appendix C: Sampling Process.....	50
Appendix D: Active Case Eligibility Sample Size.....	51
Appendix E: MEQC & PERM Sampling and Review Differences.....	58
Appendix F: Medicaid Active Case Review Process.....	62
Appendix G: CHIP Active Case Review Process.....	63
Appendix H: Medicaid and CHIP Negative Case Review Process.....	64
Appendix I: Calculating Medicaid and CHIP Eligibility Error Rates.....	65
Appendix J: Reporting Forms.....	69

## **Section 1 - Introduction**

The Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, enacted on November 26, 2002, requires the heads of Federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments to 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 the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. More information on the PERM program can be accessed at <http://www.cms.hhs.gov/PERM>.

To implement the requirements of IPIA, Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (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 will be used to produce national program error rates, as required under IPIA, as well as State-specific program error rates. CMS has developed a national contracting strategy for measuring the first two areas, FFS and managed care. 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 will use PERM to measure Medicaid and CHIP improper payments in a subset of States each year. To enable States to plan for the reviews, States will be reviewed on a rotating basis, so each State will be measured for improper payments in each program once and only once every three years.

The States that will be measured for fiscal years (FY) 2010-2012 (which rotate thereafter) are as follows:

**Table 1-1 States Selected for Medicaid and CHIP Improper Payments Measurements**

FY 2010	FY 2011	FY 2012
Alabama	Alaska	Arkansas
California	Arizona	Connecticut
Colorado	District of Columbia	Delaware
Georgia	Florida	Idaho
Kentucky	Hawaii	Illinois
Maryland	Indiana	Kansas
Massachusetts	Iowa	Michigan
Nebraska	Louisiana	Minnesota
New Hampshire	Maine	Missouri
New Jersey	Mississippi	New Mexico
North Carolina	Montana	North Dakota
Rhode Island	New York	Ohio
South Carolina	Oregon	Oklahoma
Tennessee	South Dakota	Pennsylvania
Utah	Texas	Virginia
Vermont	Washington	Wisconsin
West Virginia		Wyoming

National contractors selected by CMS will conduct the medical and data processing reviews to develop error rates in the fee-for-service and managed care components of Medicaid and CHIP. States will 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.

The PERM program is intended to fulfill the requirements of the IPIA. We are providing the option for States to contract out the eligibility measurement to entities independent of States' Medicaid and/or CHIP eligibility determination and enrollment activities. As we work with all States and gain experience with the Medicaid and 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.

On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub L 111-3) was enacted. Sections 203 and 601 of the CHIPRA relate to the PERM program. Section 203 of the CHIPRA establishes an error rate measurement with respect to the enrollment of children under the Express Lane Eligibility option. The law directs States not to include children enrolled using the Express Lane Eligibility option in data or samples used for purposes of complying with the MEQC and PERM requirements.

Section 601 of the CHIPRA provides for a 90 percent Federal match for Children's Health Insurance Program (CHIP) spending related to PERM administration and excludes such spending from the 10 percent administrative cap (Section 2105(c) (2) of the CHIP statute gives States the ability to use an amount up to 10 percent of the CHIP benefit expenditures for outreach efforts, additional services other than the standard benefit package for low-income children, and administrative costs).

The CHIPRA requires a new PERM rule and delays any calculation of a PERM error rate for CHIP until 6 months after the new PERM rule is effective. Additionally, the CHIPRA provides that States that were scheduled for PERM measurement in fiscal year (FY) 2007 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2007, or may elect instead to consider its PERM measurement conducted for FY 2010 as the first fiscal year for which PERM applies to the State for CHIP. Similarly, the CHIPRA provides that States that were scheduled for PERM measurement in FY 2008 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2008, or may elect instead to consider its PERM measurement conducted for FY 2011 as the first fiscal year for which PERM applies to the State for CHIP. The CHIPRA requires that the new PERM final rule include the following:

- Clearly defined criteria for errors for both States and providers;
- Clearly defined processes for appealing error determinations;
- Clearly defined responsibilities and deadlines for States in implementing any corrective action plans;
- Provide that the payment error rate determined for a State shall not take into account payment errors resulting from the State's verification of an applicant's self declaration; and
- State-specific sample sizes for application of the PERM requirements.

In addition, the CHIPRA aims to harmonize the PERM and Medicaid Eligibility Quality Control (MEQC) programs and provides States with the option to apply PERM Medicaid and Title XXI Medicaid expansion data resulting from its eligibility reviews for meeting MEQC requirements and vice versa, with certain conditions.

We will also introduce a revised self declaration policy for Medicaid and CHIP.

Beginning in FY 2009, States are 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. States are still responsible for fulfilling the reporting requirements for MEQC to the respective CMS Regional Office and PERM on the PERM Eligibility Review Tracking (PERT) website.

Once the final rule is in place, States are allowed the option to use their eligibility sample, eligibility review and payment review findings for Medicaid and Title XXI Medicaid expansion from the PERM reviews to meet the MEQC program requirements. Allowing data substitution will minimize the duplication of effort between MEQC and the PERM eligibility reviews. CMS continues to consider methods to minimize duplication of efforts regarding the eligibility reviews.

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, flowcharts and a timeline that illustrates the eligibility measurement process. State sampling plans are due 60 days prior to the start of the fiscal year (i.e. August 1). States are responsible for taking appropriate action to perform quality control checks on sampling universe data and selected samples to ensure accurate measurement. Eligibility reviews are conducted based on the monthly samples for the 12 month fiscal year and will encompass cases currently on the program, referred to as active cases, and cases that were denied or terminated from the program, referred to as negative cases. CMS will calculate a case and payment error rate for active cases and a case error rate for negative cases. Refer to Appendix A for a complete PERM eligibility sampling and review timeline. A glossary is provided that defines terms used throughout these instructions.

## **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 total payments made for services to beneficiaries in the sample 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, collecting payments 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 detail how the error rate for each State will be measured by creating a universe of beneficiaries, stratifying beneficiaries based on case status, and performing a random sample within each stratum to review 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 3). For the purposes of PERM eligibility, a case is defined as an individual beneficiary enrolled in Medicaid or CHIP or denied or terminated from Medicaid or CHIP. The universe will be broken into two main groups: active cases and negative cases. Active cases are those in which an individual is enrolled in the Medicaid or CHIP program in the month of the sample. Negative cases are cases denied or terminated in the month of the sample. The active case universe is broken down further into three strata. Therefore, States will draw a sample each month from the following four sampling universes:

- Stratum 1 (applications),
- Stratum 2 (redeterminations),
- Stratum 3 (all other cases),
- Negatives (denied or terminated cases).

Once the sample has been drawn, States will review each case to verify eligibility according to the procedures outlined in Section 4. For sampled active cases, States will also collect payments (see Section 5). Each State is also responsible for reporting the monthly samples, the active and negative review findings and the payment collection information to CMS (see Section 6).

The sample and subsequent review and payment collection 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 results of the active case review findings),
- The active case payment error rate—a dollar-weighted error rate based on the number of dollars paid out in error due to services being provided to an individual who was not eligible for those services (calculated from the active case payment collection),
- The negative case error rate—the percentage of the decisions in which eligibility was incorrectly denied or terminated (calculated from the results of the negative case review findings).

### **Section 3 – 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.

States must submit a sampling plan for each program including both the active and negative case samples, developed in compliance with applicable regulations and these instructions, to the statistical contractor for approval by August 1 prior to the fiscal year. The statistical contractor will work with any State to ensure the sampling plan meets the requirements in these instructions and is approved by October 1 prior to the fiscal year.

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).

Section 3 is divided into two parts. The first part describes the sample for estimating a case and a payment error rate for active cases. CMS will calculate two error rates for active cases. The first is a simple case error rate (eligible or not eligible). In addition, a “dollar weighted” or “dollar” error rate using the dollar value of payments made for services is computed. The same active case sample will be used for both the payment error rate and the case error rate.

The second part of this section describes the sampling plan for determining the case error rate for negative cases. The error rate for negative cases, which is not dollar weighted, is a case error rate only. No payments are collected for these denied and terminated cases because many times no services are rendered.

While these instructions provide States with the necessary information to ensure accuracy, States should note that the eligibility sampling universe, monthly samples and reviews should be subject to quality control procedures performed by the State to ensure that inappropriate cases are excluded from the universe and that all appropriate cases are included.

### **3-1 - Active Case Sample**

States will select a sample each month from a unique universe created for that month. The active case universe for a given month consists of all active cases on the program at any time during the month. These active cases in the sample month will be stratified into three strata: Stratum 1 (applications), Stratum 2 (redeterminations), and Stratum 3 (all other cases).

#### **3-1-1 - 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. Note that the distinction in enrollment, between the Medicaid and CHIP universes, is determined by the program funding the services, that is, a Title XXI Medicaid expansion case, although receives services under Medicaid provisions, is included in the CHIP universe if the beneficiary’s services are paid by Title XXI funds.

Exclusions from the active case universe for the active case sample each month 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;
- 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) of the Social Security 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; and
- For Medicaid only, adoption assistance and foster care cases under Title IV-E.

It should be noted that for PERM purposes, cases that are in suspended status due to certain penalties or have not met spenddown in the sample month are not inclusive to the active or negative universe.

Although these cases may be included in an actively receiving family group or assistance unit, or are categorically eligible but not financially eligible, they have not met all applicable criteria to be eligible for program benefits.

Suspended cases should only be included in the universe when the beneficiary is no longer under penalty and may receive program benefits.

Spenddown cases should only be included in the universe when spenddown is met or the case is no longer in a "pending" status. Suspended cases and spenddown cases would be included in Stratum 1.

### **3-1-2 - Sampling Stratified Active Cases**

Sampling units in Stratum 1 and Stratum 2 should be based on either 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 1 or Stratum 2 in any month prior to when the decision to grant or continue eligibility was made.

Cases in Stratum 3 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 20th. The State makes a decision on January 30th 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 1 in the January sample.

Example 2: In State B, 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 2 in the February sample.

Note: 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). There is no retroactive coverage period for CHIP. 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. Refer to Exhibit 3-1 for examples illustrating why the 3-month retroactive period in Medicaid would not fall into the universe of cases for the April sample month.

**Exhibit 3-1: 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 21st.	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 1st.	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

**3-1-3 - Stratifying Active Cases**

For each sample month, States will stratify the active case universe into three strata according to the type of active case.

Active cases strata are:

- **Stratum 1: Applications**—a case constitutes a “complete application” for the sample month if the State took an action to grant eligibility in that month based on a completed application. These cases are placed into Stratum 1. 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 1. If there is any other situation where a State reinstates an individual after a break in coverage, the State must get CMS approval to move these cases from Stratum 1 to the appropriate stratum. This information should be in the State's sampling plan upon submission.

- **Stratum 2: Redeterminations**—A case constitutes a “complete redetermination” for the sample month if the State took action to continue eligibility in the sample month based on a completed redetermination at or during the three, six, nine or twelve month redetermination period. These cases are placed in Stratum 2.
- **Stratum 3: All Other Cases**—All other cases (properly included in the universe but do not meet the Strata 1 or 2 criteria) that are on the program in the sample month are placed in Stratum 3.

PERM defines a “complete application” and a “complete redetermination” as an application or redetermination where the beneficiary met all Medicaid and/or CHIP requirements to complete the process, e.g., provided necessary financial and categorical information and signed appropriate forms. An incomplete application and an incomplete redetermination occurs when the beneficiary does not take the necessary action that would allow the State agency to determine eligibility; e.g., the beneficiary completes a written application but does not provide requested documentation of eligibility or the beneficiary does not keep an appointment to complete an eligibility redetermination.

### **3-1-4 - Stratifying Active Cases—Additional sampling situations**

**Passive renewal cases:** These cases should be treated like any other case, including placing these cases in Stratum 2 in the month the redetermination becomes effective. (The only difference will be in how these cases are reviewed when sampled in Stratum 2. See Section 4-2-6 for additional information.)

**Continuous eligibility cases:** After the being included in Stratum 1 in the initial month that eligibility becomes effective, these cases should be in the Stratum 3 universe for the remainder of the continuous eligibility period. Include continuous cases in Stratum 2 in the month the 12 month redetermination becomes effective.

**September sample:** The purpose of PERM is to calculate an error rate for a specific fiscal year. However, given that decisions made in September could become effective in October and beyond, outside the fiscal year, States should only include cases in their September universe for Stratum 1 and Stratum 2 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 15th to grant eligibility to an individual for a coverage period beginning October 1st. This case should not be included in the September sampling universe and therefore would not be sampled in the fiscal year.

**Joint Applications:** In States with a joint application for Medicaid and CHIP, the application is considered an application for each program. If a joint application is approved for Medicaid, the case would be placed in the Medicaid active universe. A joint application that is approved for CHIP would be placed in the CHIP active universe and the Medicaid negative universe in the sample month. Since States must screen for Medicaid before enrolling cases in CHIP, cases approved for Medicaid and therefore not considered for CHIP are not to be placed in the CHIP negative universe.

**SSI conversion cases:** SSI conversion cases occur when an individual no longer qualifies for SSI cash and is transitioned to Medicaid coverage by the State until the State performs a redetermination to determine if the individual still qualifies for Medicaid. 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.”

The State should place SSI conversion cases in Stratum 3 until the State redetermines eligibility.

The State 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 decision was made to terminate unless the case is being continued pending the 10-day advance notice or until an appeal is finalized.

### **3-1-5 - Sample Size for Active Cases**

The initial sample size was calculated under the assumption that the error rate was 5 percent. This means that the desired precision requirements would be achieved with a high probability if the actual error rate was 5 percent or less. For this reason, the initial sample size of 504 cases should meet State-level precision requirements with a high probability. In subsequent cycles, if the State’s actual error rate is below 5 percent, the State may demonstrate that a smaller sample size based on the documented lower error rate is sufficient to achieve the desired precision requirements.

The case for a smaller sample size should be made in the State’s next sampling plan for subsequent years, along with the documentation and analysis to demonstrate that a smaller sample size will achieve required precision goals. States with error rates above 6 percent cannot petition for a smaller sample size.

If the total population from which the total (full year) sample is drawn is less than 10,000 individuals, the State may propose to reduce the sample size by the finite population correction (FPC) factor, which is discussed in Appendix D. If so, the required sample size becomes:

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

Sample sizes should be sufficient to meet the precision requirements, which is to estimate the active case payment error rate within 3 percentage points of the population mean error rate with a 95 percent level of confidence. Sample sizes differ depending on the State's underlying error rate, but each State must always sample an equal number of applications, redeterminations and all other cases each month. Exhibit 3-2 shows the probability of achieving the desired precision for a given sample size and assumed error rate. If the underlying error rate is in the range of 3 to 4 percent, a sample size of 504 total cases will achieve the desired precision level with very high probability. Moreover, a sample of 504 will achieve the precision level more than 50 percent of the time with an error rate as high as 6 percent.

**Exhibit 3-2: Probability of Achieving Precision for Certain Error Rates and Sample Sizes**

	Error Rate					
Sample Size	0.03	0.04	0.05	0.06	0.07	0.08
<b>250</b>	49.2%	6.0%	0.4%	0.0%	0.0%	0.0%
<b>300</b>	86.5%	26.3%	2.7%	0.2%	0.0%	0.0%
<b>350</b>	98.8%	62.7%	13.5%	1.3%	0.1%	0.0%
<b>400</b>	100.0%	90.4%	39.9%	6.9%	0.7%	0.0%
<b>450</b>	100.0%	98.9%	73.0%	23.8%	3.6%	0.3%
<b>500</b>	100.0%	100.0%	93.2%	52.8%	13.7%	1.9%
<b>600</b>	100.0%	100.0%	99.9%	95.3%	64.2%	22.9%
<b>650</b>	100.0%	100.0%	100.0%	99.4%	86.6%	47.7%
<b>700</b>	100.0%	100.0%	100.0%	100.0%	96.9%	73.7%

**3-1-6 Method for Drawing the Monthly Sample**

States will draw the sample over the course of the entire 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, stratify the cases in the universe for that month into Stratum 1, Stratum 2 and Stratum 3 and sample cases within each strata. To determine whether Stratum 1 or Stratum 2 applies, the State should evaluate the decision date or the effective date of the action, whichever month is later applies. The Stratum 3 universe should consist of cases where the beneficiary is receiving Medicaid or CHIP coverage and is not a new application or redetermination in that month.

Note that over the sampling timeframe, cases will appear in the universe more than once, may be in different strata in different months, or may be randomly sampled in more than one month over the course of the fiscal year. Because a unique universe is drawn each month, a beneficiary could appear in Stratum 1 in a month and Stratum 3 the next month, and in Stratum 2 or Stratum 3 the following month. Given the small size of the sample, it is unlikely that a beneficiary will be randomly selected more than once. However, if the case is selected in more than one month, it should not be dropped and replaced with another case, but instead should be included in the sample.

The active case sample size is drawn from the full twelve months of the Federal fiscal year, as shown in Exhibit 3-3 and equals a total of 504 cases. Unless the State has an approved

alternative due to the finite population correction<sup>1</sup>, or a reduced sample size based on prior data, States using the initial or base sample size will sample 14 cases each month in each stratum for the twelve month Federal fiscal year. For subsequent cycles of PERM reviews, active case sample sizes will depend on the State's most recent error rate. Each monthly sample must have the same number of cases sampled for each stratum.

---

<sup>1</sup> If the State's universe for the previous fiscal year is less than 10,000, it may demonstrate in its sampling plan to apply the finite population correction to reduce its sample size.

### Exhibit 3-3: Initial Active Case Sample Size by Stratum

Stratum	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
<b>Applications</b>	14	14	14	14	14	14	14	14	14	14	14	14
<b>Redeterminations</b>	14	14	14	14	14	14	14	14	14	14	14	14
<b>All Other Cases</b>	14	14	14	14	14	14	14	14	14	14	14	14

Within the strata, the required number of cases should be sampled randomly, as soon as possible after the end of the sample month, once the universe for that month is determined. However, the sample should be drawn and reported to CMS, via the PERM Eligibility Review Tracking (PERT) website, no later than the 15th day of the month following the sample month (see Section 6).

A State can only drop and replace a case from the PERM eligibility sample for the following reason:

- a case is found to be under active beneficiary fraud investigation.

There are, however, other sampling situations that might require a State to adjust the sample and the universe after it has already been pulled including when:

- a case which should have been excluded from the sampling universe was inadvertently included in the universe and sampled (this includes a case that upon further review was inadvertently included in the wrong stratum or was a State-only case and was sampled); or
- a case was enrolled in Medicaid or CHIP using States' Express Lane Eligibility option, set forth in Section 1902(e)(13) of the Act although these cases should be coded in a way that they could be excluded from the sampling universe.

States should take steps prior to sampling to ensure that these potential errors in the universe do not occur. However, if a State identifies a problem with the Medicaid and CHIP eligibility universes which would require changes to the sample, States should contact the Statistical Contractor immediately upon identification with specific information regarding why the sample is being changed. If problems are identified in the sample, States must ensure that their universe totals are accurate. States may also need to resubmit a revised sample list to the PERT website, if the issue is identified after the initial sample has been submitted. When developing the sampling plan, States should consider the potential need for randomly selected replacement cases and may want to oversample.

The following are examples of valid reasons to drop a case from the PERM universe.

Example 1: A State samples a case in Stratum 3. Upon review of the case, the beneficiary is found to be under active beneficiary fraud investigation. The State should drop this case and replace the case with one that has been oversampled.

Example 2: A State samples a case in Stratum 2, but upon further review finds that the case is a Stratum 3 case that was inadvertently placed in the Stratum 2 universe. The State should drop this case and replace the case with one that has been oversampled, as well as determine if the issue is systemic and correct universe totals, if possible.

We do not anticipate that problems of this nature will occur often, so oversampling should be kept to a minimum. If a State finds repeated errors in its universe or samples, the State must develop a revised universe and stratum assignment approach to ensure that systematic errors in the universes are corrected before continuing with monthly sampling.

### **3-1-7 - States Substituting MEQC Data**

States that elect to substitute their MEQC data to meet the PERM eligibility requirement do not need to stratify their Medicaid and/or Title XXI Medicaid expansion (CHIP) universes into the three strata. States with a CHIP stand alone or combination program will still need to stratify the non-Medicaid expansion (under Title XXI) component of the CHIP universe. Sampling should be conducted in accordance with the State Medicaid Manual at Section 7100.

We ask that although States using MEQC data cannot stratify the MEQC universes or samples before the eligibility review that once the sample is drawn and upon review, States identify applications, redeterminations and all other cases in their sample when reporting the eligibility review findings.

The MEQC sample size must meet PERM confidence and precision requirements.

Although the exclusions for MEQC differ for PERM, States must identify and exclude cases in their MEQC sample that must be excluded from the PERM sample. See Section 7123 of the State Medicaid Manual for MEQC sampling exclusions. States can apply these exclusions, but also must apply PERM exclusions (see Identifying Active Case Universe) if using the MEQC sample to meet PERM eligibility requirements. The MEQC sampling exclusions are:

- Those cases for which Medicaid eligibility was determined by SSA in 1634 contract States;
- Cases eligible for Medicaid based on title IV-E adoption or foster care;
- Cases funded 100 percent by the Federal Government; and
- Retroactively eligible cases.

Section 7230 of the SMM lists acceptable reasons for States to not complete an MEQC review on a case. If any of these reasons result in an “Undetermined” PERM finding as discussed in Section 4.5, these cases may be dropped for MEQC purposes, but **must not be dropped** for PERM. These cases must be verified for eligibility through other reasonable evidence or reported as Undetermined for PERM purposes. The acceptable reasons for States to drop a case from the MEQC review are:

- Beneficiary does not cooperate;
- Beneficiary cannot be located;

- Beneficiary moved out of State;
- Beneficiary has requested an appeal of an eligibility determination.

### **3-2 - 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.

#### **3-2-1 - Identifying the Negative Case Universe**

A unique universe is created each month. All cases where the State denied eligibility in the sample month or terminated eligibility in the sample month should be included in the negative universe for that month. Denials and terminations included in the universe must be based upon a completed application or redetermination in which the applicant or recipient signed all applicable forms and submitted all applicable verification. All other active cases including 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 excluded from the respective month's negative case universe. There are no provisions for States to drop cases from review and replace them with other cases unless they do not belong in the negative case universe.

#### **3-2-2 - Sampling the Negative Case Universe**

The universe for the negative case sample is uniquely determined each month and includes all actions the State took to deny or terminate eligibility in that month.

#### **3-2-3 - Sample Size for Negative Cases**

The initial size of 204 is required. However, if the State's universe for the previous fiscal year is less than 10,000 individuals, it may request to apply the finite population correction to reduce its sample size. The State should make the case for a reduced sample size based on the finite population correction in its sampling plan, as indicated in Section 3-1-5. However, the reduction is likely to be small.

The negative case error rate is not dollar weighted; it is a simple binomial. The equation for the sample size is the same as the equation for active cases and can be found in Section 3-1-5 Sample Size and in Appendix D, except that K is zero:

#### **Exhibit 3-4: Negative Case Sample Size Formula**

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

The required sample size is that which is sufficient to obtain a precision level of 3 percentage points at the 95 percent confidence level for the negative case error rate. If the error rate is less than 5 percent, a sample size of 204 will achieve the precision level more than 50 percent of the time. If the error rate is 3 percent or 4 percent, a sample size of 204 will achieve the precision goal with a high probability.

#### **3-2-4 - Method for Drawing the Monthly Sample**

The initial sample will be drawn from this universe of negative cases over the entire twelve months of the Federal fiscal year. The sample size should consist of 17 cases for each month of the Federal fiscal year, as shown in Exhibit 3-5.

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 obtain the case records. Please refer to Appendix D for information on ways to draw the random sample.

The monthly samples should be subject to quality control procedures to ensure that the appropriate cases were included in the universe, and that inappropriate cases excluded. A monthly sample selection list must be sent to CMS and the statistical contractor via the PERT website by the 15th day of the month following the sample month and prior to commencing the reviews as specified in Section 6.

**Exhibit 3-5: Sample Size for Negative Cases**

<b>Stratum</b>	<b>Month</b>											
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
<b>Negative Determinations</b>	17	17	17	17	17	17	17	17	17	17	17	17

**3-2-5 - Substituting Negative Findings**

States in their PERM year have the option to use their negative PERM reviews to meet their MEQC negative case action requirement. 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 case, active case reviews will remain two separate processes.

**Section 4 Eligibility Reviews of Active Cases**

All sampled active cases are reviewed to verify that the individual was eligible for the program. All case reviews must be conducted by an agency independent (i.e., agency and personnel must be functionally and physically separate) of the State agency responsible for Medicaid and CHIP policies, operations, and program eligibility determinations. The State agency should not be housed in the same office or division as the State agency responsible for eligibility to the extent that both agencies are commingled and report to the same immediate supervisor, for example, a first-line manager or Division Director. The requirement helps ensure the independence of the reviews. However, this requirement does not preclude the State from placing the agency responsible for the PERM eligibility reviews within the same single State or umbrella agency as the agency responsible for the program’s policies, operations and eligibility determinations, provided that both agencies do not report to the same immediate supervisor or manager who has direct oversight or responsibility for program policies, operations, and eligibility determinations. The State must identify the agency or the contracting entity responsible for the eligibility reviews in its sampling plan with a stated assurance that the agency is independent of the State agency responsible for eligibility determinations and enrollment or that the contracting entity is independent of the State’s eligibility and enrollment activities.

#### **4-1 - Review Month**

For PERM purposes, the review month is when the State's last action occurred and should be the month for which eligibility is verified.

For Stratum 1 cases, the review month is the month in which a decision was made to grant eligibility. .

Example: The State samples a case in June in stratum 1 with a decision date of May 25th. The review month would be May and the state would review the new application.

For Stratum 2 cases, the review month is the month in which a decision was made to extend eligibility coverage.

Example: The State samples a case in June in stratum 2 with a decision date of May 25th. The state would review the redetermination as of May.

For cases in Stratum 3, the review month is the month of the State's last action and is different from the sample month.

Example: The State samples a case in June in stratum 3. The last action taken in the case was in January. The review month would be January and eligibility would be verified for the month of January.

The exception to verifying eligibility as of the review month is when the State's last action for a Stratum 3 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.

Example 1: A Stratum 3 case is sampled in January 2010. The State's last action (the review month) occurred in May 2009. Eligibility for this case is verified as of the review month of May 2009.

Example 2: A Stratum 3 case is sampled in January 2010. The State's last action (the review month) occurred December 2008. Since the last action occurred more than 12 months prior to the sample month of January 2010, eligibility is verified for January 2010.

If a case in Stratum 3 is sampled in Stratum 3 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 the sample month, an additional verification of eligibility is not necessary because eligibility already has been verified as of the State's last action when previously sampled. However, if the action occurred beyond 12 months from the sample month, new eligibility verification is necessary as of the sample month because case circumstances may have changed from the eligibility verification done when the case was previously sampled.

If a case is sampled more than once over the course of the measurement process and appears in a stratum different from the stratum it was in when first sampled, verify eligibility using the rules of the stratum in which the case is currently sampled.

There is no administrative period for the PERM eligibility reviews. The administrative period is defined under 42 CFR Section 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 review month and the prior month.

We are not applying this concept to the PERM eligibility reviews for the following reasons:

- 1) The administrative period is not applicable for those cases in Strata 1 and 2 because these cases are reviewed as of the State's most recent action.
- 2) For cases in Stratum 3, eligibility is also verified as of the State's last action unless that action occurred beyond 12 months from the sample month. In those instances, the administrative period would not be applied because the State should not be held harmless when it has not complied with the requirements of 42 CFR 435.916(a) and 457.320(e) (2) to redetermine eligibility at least annually.

#### **4-2 - 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 (so long as the criteria comply with the State plan or, if the plan is silent, Federal laws and regulations). The standards discussed below determine the extent to which the review obtains evidence relevant to the beneficiary's eligibility or ineligibility. CMS has established these standards to provide a systematic and nationally uniform method of verifying eligibility. 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.**

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.

##### **4-2-1 – Required PERM Verification**

Required verifications for PERM eligibility reviews (regardless of whether these criteria were self declared) are:

- Citizenship (must be present in case record)
- Residency

- Household composition
- Bank Accounts
- Earned and Unearned income
- Enrollment in the plan for managed care beneficiaries.

Documentation must be present in the case record and current (not more than 12 months old, accept when citizenship is appropriately verified). If these elements are present and current, the agency may make a review decision based on this verification. If these elements are missing or outdated and likely to change, they must be independently verified using the verification standards below in Section 4-2-2.

For CHIP, the agency must verify these elements through documentation in the case file, or through a new self-declaration statement from the beneficiary that meets the self declaration requirements described in Section 4-2-3 and 4-2-5, depending on State policies on self-declaration. The new self declaration statement should contain information that is consistent with the evidence in the case file.

#### **4-2-2 - Acceptable Documentation**

The agency must examine the evidence in the case file and independently verify elements of eligibility where evidence is: (1) missing or (2) outdated and likely to change. Outdated evidence is evidence that is older than 12 months prior to the sample month. Exhibit 4-1 lists the categorical and financial criteria that are or are not likely to change.

**Exhibit 4-1: Criteria Likely or Not Likely to Change**

<b>Categorical Criteria Unlikely to Change</b>	<b>Financial Criteria Unlikely to Change</b>	<b>Categorical Criteria Likely to Change</b>	<b>Financial Criteria Likely to Change</b>
Citizenship (in month eligibility is being verified)	Cash—Resource	Residency	Bank Account—Resource
Social Security Number	House, other property—Resource	Household Composition	Earned income—e.g. wages and salary
Death	Vehicle—Resource		Unearned income—e.g. retirement and government benefits
Birth Date	Life Insurance—Resource		
Pregnancy (in month eligibility is being verified)	Personal effects (e.g. boat, camper)—Resource		

Sufficient evidence of documentation in the case file includes:

- 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 household composition: “Visit to John Jackson’s residence at 1234 Summerville Court. Mr. Jackson, his wife Nancy and son John Jr. live in the home.”
  - To verify income: “Conducted a home visit and verified Bank of America statement for checking account #12345, dated March 2007, with an ending balance of \$55.07 and no unusual deposits or withdrawals other than the Social Security benefit of \$700.”
- Permanent documents (e.g. birth certificate, Social Security card, etc., regardless of when the document was obtained); and
- Information from other agencies or databases or electronic records.

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.

Please refer to Section 4-2-2 for more information on when independent verification is needed to verify eligibility for Medicaid and for CHIP.

#### **4-2-3 - Acceptable Self Declaration**

CMS allows States to accept self-declaration of certain categorical and financial eligibility criteria as a means to simplify the application and redetermination eligibility processes. For example, rather than requiring documented proof such as a birth certificate, some States accept a signed statement, under penalty of perjury, as proof of birth date or age.

Some States also accept a signed statement for other categorical and financial criteria as long as there is no Federal requirement to document the information, such as the Deficit Reduction Act of 2005 (DRA), which requires documentation of citizenship for Medicaid effective July 1, 2006. 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). States should refer to Federal Medicaid and CHIP eligibility rules at 42 CFR Par 435 and Part 457 for citizenship verification and other Federal verification requirements.

#### **4-2-4 - Self Declaration for Medicaid**

For Medicaid, self-declaration is considered acceptable verification for the PERM review for meeting categorical and financial eligibility verification requirements listed as unlikely to change in Exhibit 4-1 and are not required by Federal law or regulation. The self-declaration must be in accordance with official written State policy, and the attestation must be:

- Not older than 12 month prior to the sample month;
- In a State-approved, valid format, e.g., signed on a document, under penalty of perjury; and
- Consistent with other information in the case file, or if inconsistent, evidence in the case file resolves the inconsistency.

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

PERM reviewers may also conduct phone interviews with sampled beneficiaries to verify eligibility criteria unlikely to change for Medicaid if verification for these criteria is missing from the case record. Reviewers may complete a worksheet or some other instrument that is used to document a review. Document the date and time of any contacts with the beneficiary and the beneficiary's statements for likely to change eligibility criteria.

#### **4-2-5 - Self Declaration for CHIP**

For CHIP, self declaration is acceptable verification for the PERM review for meeting categorical and financial requirements listed as unlikely to change in Exhibit 4-1, depending on State policies on self-declaration and the self-declaration must meet the standards listed above.

To verify eligibility criteria likely to change, States may use either documentation in the case record or a new self declaration statement obtained from the beneficiary. The new self-declaration statement is acceptable for the PERM review if it is not inconsistent with facts in the case record or resolves inconsistencies in the case record.

If the new self-declaration is not acceptable verify eligibility through other reasonable evidence, i.e. third party sources. Cite the case as "undetermined" if the agency cannot obtain reasonable evidence to complete the review.

For CHIP, a signed statement may serve as a new self declaration statement for likely to change eligibility criteria after a phone interview is conducted. PERM reviewers may complete a worksheet or some other instrument that is used to document a review. The worksheet or other instrument may serve as documentation of the phone interview. The PERM reviewer must document all attempts to contact the beneficiary, date and time of the interview and document client statements for likely to change eligibility criteria.

#### **4-2-6 - Simplified Enrollment and Passive Renewal for Applications and Redeterminations**

Section 212 of CHIPRA provides for reducing administrative barriers to enrollment for children and pregnant women in Medicaid and CHIP. Under CHIPRA States are encouraged to use joint applications and allow for enrollment into the programs without face to face interviews. In some States, depending on policies in their State plans, redeterminations are conducted through passive renewal (or passive redetermination), in which there is no required follow up by the recipient if there are no reportable changes in circumstances.

For Medicaid, the eligibility worker is required to check the Income and Eligibility Verification System (IEVS) (Section 1137 of the Social Security Act and 42 CFR 435.940 through .965) to confirm the income of an applicant during the processing of an application or renewal. This system looks at the Internal Revenue Service (IRS), Social Security Administration (SSA), State quarterly wage reports and Unemployment Benefit Information.

In CHIP, CMS encourages verification of self-declared income using these sources but there is not a requirement to do so. However, States that use a combined Medicaid-CHIP application are required to perform screen and enroll procedures which may include a full Medicaid review of income eligibility if a child or family is potentially eligible for Medicaid after a screening.

Simplified enrollment policies in which a client's circumstances are self declared and passive renewal for PERM eligibility is acceptable self declaration policy for the PERM review as long as client circumstances are documented in the case record and can be substantiated for the PERM review. This includes, but is not limited to:

- An eligibility worker describes their process for verifying income eligibility using IEVS and IVES information is used for the PERM review decision;
- An eligibility worker describes the process and results for screen and enroll procedures for Medicaid and the Medicaid verification is used to substantiate the PERM review decision;
- The PERM reviewer uses Medicaid documentation from a full Medicaid review conducted before an applicant is enrolled into CHIP and the Medicaid documentation is used for the PERM review decision.
- Upon redetermination of a case, an eligibility worker completes a passive renewal redetermination form documenting case circumstances in which the case is being continued for eligibility and places it in the case record along with a copy of the renewal letter mailed to the beneficiary.

#### **4-3 - PERM Technical Errors**

PERM technical errors are errors that would not result in an improper payment. Technical errors for purposes of PERM are, but are not limited to:

- Failure to follow State administrative procedures that do not affect eligibility if acceptable documentation is otherwise obtained which supports that the beneficiary is eligible;
- Requirements for a separate Medicaid application (inapplicable to CHIP screen-and-enroll requirements);
- Failure to apply for other program benefits for which the individual is eligible (e.g., food stamps or SNAP) and the benefit, if received, would fail to 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; and
- Failure to record proper verification of pregnancy if later documentation established pregnancy in the month eligibility is being verified, e.g., baby's birth certificate, hospital records showing date of birth.

States may document technical errors internally and include analysis of technical errors and corrective actions for technical errors in their corrective action plans.

#### **4-4 - Process for Conducting Medicaid and CHIP Active Case Reviews: Other Review Situations**

The process for verifying Medicaid and CHIP eligibility is outlined below. Note that because CHIP has the unique requirement that applicants must be screened for Medicaid eligibility, Step 3 is added to this process to verify that the CHIP case is not Medicaid eligible. For flowcharts of the Medicaid and CHIP active case review processes, please see Appendices F and G, respectively.

##### **4-4-1 - Presumptive Eligibility**

Note that 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 with breast or cervical cancer,
- Children, and
- 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 allows States to enroll beneficiaries, for a limited time, before they are required to file a full application. These cases are reviewed according to State

eligibility criteria as long as they comply with the State plan and Federal law. Verify whether the case is within the presumptive eligibility period. If so, cite the case as eligible. If not, verify that, for Medicaid, an application was filed and the beneficiary is eligible for the program.

The CHIP program also provides for presumptive eligibility. Verify CHIP eligibility according to State policies governing the coverage group under which the person is receiving benefits.

#### **4-4-2 - Continuous Eligibility**

Continuous eligibility is when coverage is extended to a beneficiary at time of application or redetermination for a predetermined period without regard to changes in income as provided by Federal Medicaid law at Section 1902(e)(12) of the Act or applicable CHIP law or regulations. To review cases in continuous eligibility status, verify eligibility as of the date the State took the action to grant continuous eligibility based on an application or redetermination. However, if the State's last action occurred 12 months before the sample month, eligibility is verified as of the sample month, unless the State is operating under a CMS approved demonstration waiver. For CHIP, eligibility can be verified through documentation in the case record, or a new self declaration statement. If a new self declaration statement cannot be obtained, or inconsistent with facts in the case record, other reasonable evidence can be used to complete the review. Since "likely to change" eligibility criteria are not relevant to continuous eligibility cases, changes that have occurred during the continuous period and identified during the PERM eligibility review should not have any bearing on the eligibility review decision.

#### **4-4-3 - SSI Conversion Cases**

For SSI conversion cases, Federal regulations at 42 CFR 435.1003 limits Federal financial participation to the end of the month after SSA notifies the State of the loss of SSI (if received before the 10<sup>th</sup> of the month) or until the end of the next month (if notification is received after the 10<sup>th</sup> 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 bases and the State must promptly redetermine eligibility to see if the person is eligible under another category. If sampled, 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.

#### **4-5 - Process for Verifying Active Case Eligibility**

**Step 1:** Determine the review month for the case. Identify the date of the last State action taken on the case. If the last action was taken within 12 months of the sample month, the last action month is the review month to be used to verify eligibility. If the last action was taken beyond 12 months from the sample month, verify eligibility as of the sample month (see exception for continued eligibility demonstrations).

**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). Examine the evidence in the case file that supports categorical and financial eligibility. Verify information that is missing, more than 12 months old and likely to change, or inconsistent with other facts, unacceptable under self declaration guidelines, or required under these instructions. For CHIP, States may verify eligibility using documentation in the case record or a new self declaration statement for the PERM review, depending on State policies on self-declaration. If a new self declaration statement cannot be obtained or it is inconsistent with other facts, verify eligibility using other reasonable evidence.

**Step 3:** For CHIP cases, verify whether the beneficiary was ineligible for Medicaid.

- If the beneficiary was ineligible for Medicaid, continue to Step 4.
- If the beneficiary was eligible for Medicaid, cite the case as “not eligible” for CHIP and proceed to Step 5.

**Step 4:** Verify program eligibility. For Medicaid, verify eligibility for the Medicaid coverage group in which the person is receiving services based on acceptable documentation as described in Section 4-2-2. For CHIP, verify that the case is eligible based on acceptable documentation by meeting all CHIP eligibility criteria.

- If the beneficiary is eligible, cite the case “eligible” and determine whether the beneficiary was enrolled in managed care (discussed below).
- If the beneficiary is ineligible for the coverage category, determine eligibility for other related coverage categories.
  - If after examining all related categories, the beneficiary is still ineligible for the program, cite the case as “not eligible” and proceed to Step 5.
  - If the beneficiary is eligible for the program but under another coverage category or is found to have received services not applicable to the coverage category in which the case is currently enrolled, cite the case as “eligible with ineligible services” and determine whether the beneficiary was enrolled in managed care. Note that “ineligible services” in some instances will not be identified until a payment review is conducted.
- Determine whether the beneficiary was enrolled in managed care.
  - If the beneficiary was not enrolled in managed care, proceed to Step 5.
  - If the beneficiary was enrolled in managed care, verify residency and determine whether the beneficiary was eligible for managed care and enrolled in the correct plan. The agency should review the State’s managed care enrollment criteria to establish whether the beneficiary is eligible for managed care and , if so, that the beneficiary was enrolled in the correct managed care plan and living in the correct

geographic area in the State, if applicable, as of the month eligibility is being verified.

- If the beneficiary was ineligible for managed care, cite the case as MCE1 (managed care error, ineligible for managed care) or was eligible for managed care but was enrolled in the wrong plan, cite the case MCE2 (managed care error, eligible for managed care but improperly enrolled) and proceed to Step 5.
- If the agency cannot verify eligibility or ineligibility, the following process must be followed prior to citing the case as “undetermined.” When information cannot be obtained from a review of the case record and/or through independently obtained documentation or outside sources such as employers, contact the beneficiary to obtain the needed information. Listed below are the minimum efforts (all of which must be performed) required to contact the beneficiary.
  - 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; and
  - Two contacts with reliable collateral sources (e.g. landlord, relative, authorized representative allowed to provide information concerning the beneficiary, employers).

In addition, the agency may opt to make an unannounced in-person visit to the beneficiary’s place of residence. If the beneficiary is not home, contact neighbors to determine whether the beneficiary still resides at the address or at another address.

When the agency has followed all these procedures and is unable to obtain sufficient information to verify eligibility through other reasonable evidence, cite the case “undetermined” and proceed to Step 5. Note that these cases should not be cited “eligible” or “not eligible” and should not be dropped from review. The agency must record all actions, including dates and times, taken to contact the beneficiary before citing the case “undetermined.”

States that are using MEQC reviews to meet PERM requirements may also use other reasonable evidence to complete the PERM reviews if the State cannot contact the beneficiary to complete the MEQC review. Cases in which the beneficiary cannot be contacted must not be dropped. For PERM purposes, cases that cannot be resolved with other reasonable evidence are considered undetermined and will be factored into the Medicaid and CHIP error rates.

**Step 5:** Record the Medicaid or CHIP case review finding “eligible,” “not eligible” or “undetermined”, etc. (Managed care cases that are eligible for Medicaid or CHIP are considered as eligible cases but record the amount of misspent dollars associated with any managed care errors for inclusion in the error rate calculation). Cases with findings of not eligible or with

managed care errors, liability errors, etc. should be forwarded to the State agency responsible for eligibility determinations so appropriate actions on individual cases can be taken. **Note:** When a case is found to be ineligible, the case should not be terminated from the program by the PERM reviewer. The correct action is to refer the case to the caseworker for a redetermination.

Document technical errors as appropriate so that the State can take corrective actions to reduce or eliminate these types of errors. The State does not need to document technical errors on the PERM reporting forms but States may add to the list provided by CMS depending on State policies that were misapplied but do not affect eligibility of a case.

**Note:** States can cite a case as “undetermined” if, after due diligence, an eligibility review decision could not be made. States will identify payments made on behalf of the particular beneficiary for services received in the first 30 days of eligibility or sample month, as appropriate. 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.

It should also be noted that a beneficiary’s 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. We reiterate that an error case or undetermined case should be referred back to the eligibility agency for a redetermination.

#### **4-6 - 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. For a flowchart of the Medicaid and CHIP Negative Case Review Process, please see Appendix H.

Each month, the State will randomly select a negative sample of cases for review. For each case, agencies must:

**Step 1:** Review the notice of action to identify the reason the State denied or terminated eligibility. Reasons for denials and terminations of Medicaid or CHIP can be for any circumstances, e.g. 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 documentation 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 4-2-1

Acceptable Documentation in these instructions as well as Section 7269 of the State Medicaid Manual.

- 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, e.g. the State erroneously terminated eligibility based on excess income but the review verified that the person did not have excess income but that the termination was actually correct because the case has excess resources.
  - If the evidence indicates another reason for denial or termination, cite the case as correct.
  - If no evidence exists to support the denial or termination, especially if caseworker notes indicate that documents are filed in a case record that is missing, verify the denial or termination through other reasonable evidence
  - Cite the case “improper denial” or “improper termination” if no evidence exists to support the denial or termination.

**Step 3:** Record the negative case review finding “correct”, “improper denial” or “improper termination”. Improper denial and termination case findings should be forwarded to the State agency responsible for eligibility determinations so appropriate action on individual case can be taken. For example, for improper denials and terminations, the State may evaluate the beneficiary’s possible program reinstatement. Document technical errors as approved by CMS so that the State can take corrective actions to reduce or eliminate these types of errors.

Please note that there must be evidence to support a negative action, so there are no circumstances in which undetermined cases are cited as a negative finding. It should also be noted that notice of negative action to the beneficiary is a Federal requirement (42 CFR 431.211 and 42 CFR 457.1180)

## **Section 5 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 collect the claims and managed care payments associated with the cases in the sample. The dollar values of the payments and payment errors associated with these cases will form the basis of the dollar-weighted error rate.

States must wait 5 months following the sample month before collecting claims. For cases in Strata 1 and 2, 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 3 are identified as of the sample month. Only include payments paid in that month and in the four months following that month (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.

**Exhibit 5-1: Example of Timeframe to Collect October Payments**

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

Claims are collected 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. The date of coverage dictates how the agency will associate the claims.

- In States with full month coverage, the agency would associate all payments for services received in the sample month.  
Example: An applicant applies for Medicaid and is eligible on October 15<sup>th</sup>, but the State makes eligibility effective October 1. The State would collect payments for services received in October, and paid in October, November, December, January and February plus all adjustments made within 60 days of the paid dates.
- In States with date-specific eligibility, the agency would associate all payments for services received in the first 30 days of eligibility.  
Example: An applicant applies for Medicaid and is eligible on October 15<sup>th</sup>. The State would associate all payments for services received in the first 30 days of eligibility, beginning October 15<sup>th</sup> and paid from October 15<sup>th</sup> through November, December, January and February 15<sup>th</sup> plus all adjustments made within 60 days of the paid dates.
- In States with prospective coverage, the agency would associate all payments for services received in the month coverage becomes effective, e.g. the sample month if the effective date is later than the decision date, or the first 30 days of eligibility begin in a month after the decision date.  
Example: An applicant applies for Medicaid and is granted eligibility in October in which coverage begins November 1. The State would associate all payments for services received in November and paid in November, December, January, February and March plus all adjustments made within 60 days of the paid dates.
- For all cases in Stratum 3, the agency would associate all payments for services received in the sample month.  
Example: A case is sampled in Stratum 3 in October. The State would collect payments for services received in October and paid in October, November, December, January and February plus all adjustments made within 60 days of the paid dates.

**Note:** The PERM eligibility reviews will not encompass the three-month retroactive period in Medicaid, i.e. the three month period prior to the month of application. (CHIP has no retroactive eligibility period.) For beneficiaries who are provided coverage for this retroactive period, States should not collect payments made for or during that timeframe.

States must also note that PERM applies all correct and improper payments to the payment error rate. States that elect to substitute MEQC data for the PERM reviews may not apply any error thresholds allowed under MEQC to the PERM payment reviews.

### **5-1 - Other Payment Collection Situations**

Please note that many States make premium payments to an employer for employee-based health insurance. The premium payments are made based on the eligibility of the employed household member. Therefore, during the payment review, health insurance premium payments made to an employer for employee-based health insurance should not be included when a family member other than the employed family member is sampled. The reason is that other family members could be ineligible but, since the premium payment is based on the employed family member's eligibility, we would consider the payment to be correct. However, if the employed family member's eligibility is being reviewed, then the premium payment should be included in the payment review.

All managed care payments made for coverage in the review month for Strata 1 and 2 cases or in the sample month for Stratum 3 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 or the month following the month of coverage. Prospective payments for the sample month will be counted.

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

In some States beneficiaries 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 for these cases should consider whether or not the beneficiary's premium payment was calculated correctly to determine whether or not there is a payment error. The payment amounts reported should not include the premium amount, but the amount paid with State and Federal dollars.

Also, in the review month or sample month, 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 (§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 (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.

In some States, beneficiaries 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. In these instances, all payments, managed care, fee-for-service or both must be included in the eligibility payment review.

## **5-2 - 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:** Collect claims and capitation payments for services received within the:

- The sample month, or first 30 days of eligibility for Strata 1 and 2 cases according to a State's policy on effective date of eligibility, or;
- The sample month for Stratum 3 cases.

Tally the payment amounts for services received in the first 30 days of eligibility or the sample month as applicable.

Example: A beneficiary in a State that grants full-month coverage is sampled in Stratum 1 in January. Payments should be collected for services received in January and paid in January, February, March, April and May.

Note: The PERM eligibility reviews measure improper payments that are paid within a fiscal year. However, due to the lag in payment collection and in order to ensure a complete measurement, payments made outside of the fiscal year should be collected for services received within the fiscal year. See example chart below.

**Exhibit 5-2: Five Month Payment Collection Falling Outside the Fiscal Year**

FY 2010				FY 2011				
June	July	August	September	October	November	December	January	February
Service Received	X	X	X	X				
	Service Received	X	X	X	X			
		Service Received	X	X	X	X		
			Service Received	X	X	X	X	

A State may wait another 60 days after the paid dates to apply adjustments.

**Step 2:** 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 overpayment or liability underpayment error depending on whether the beneficiary paid too little or too much toward his cost of care. The payment review should also determine whether the beneficiary as eligible for the services received. For example, if a beneficiary is eligible for Medicaid as medically needy (which has limited benefit packages) and received a wide range of services, the case may be “eligible with ineligible services” if the beneficiary received services not covered under the medically needy group according to the State’s plan. Payments for services for which the beneficiary is not eligible to receive are considered improper and are included in the error rate calculation. Although “eligible with ineligible services” results in a payment error, the case review decision of eligible should be counted as correct. Managed care cases that are eligible for Medicaid or CHIP are considered as eligible cases but record as improper payments any amount of misspent dollars associated with managed care errors, for example, ineligibility for managed care or improper enrollment in a plan.

**Step 3:** Record the amount of correct payments and the amount of dollars in error, if any. States must be able to separately identify overpayments and underpayments.

**Step 4:** For “undetermined” cases where eligibility could not be verified, collect 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. **Note:** Payments collected for cases found to be “undetermined” should be reported on the Detailed Payment Review Findings submission form.

States must complete and report payment reviews within 60 days after the first day of the month in which the claims collection process ends. Section 7 includes a discussion of reporting due dates.

## **Section 6 Reporting**

States must report the following information per program for active and negative cases:

- By August 1, prior to the Federal fiscal year, a Medicaid sampling plan and a CHIP sampling plan, based on the universes of beneficiaries in the program and persons whose benefits were denied or terminated;
- On the 15<sup>th</sup> day of the month following each sample month (and before the reviews commence) monthly sample selection lists detailing the active and negative cases selected for review (from the previous month's universe);
- By the 150<sup>th</sup> day from the end of each sample month, the detailed eligibility findings based on 100 percent of the eligibility reviews for the month;
- Within 60 days after the first day of the month in which the claims collection process ends, the payment review findings on each sampled case, that is, within 210 days of the end of the sample month for 100 percent of the cases reviewed in that month;
- By July 1 following the Federal fiscal year, summary eligibility and payment findings for each program.

**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 the four reporting forms (Monthly Sample Selection, Detailed Active Case Review Findings, Negative Case Review Findings, and Active Case Payment Findings) for each sample month using the PERM Eligibility Review Tracking (PERT) website and the corresponding Excel spreadsheets. States should also submit the final Summary Report using the data provided on the PERT website and submit them to CMS at the end of the cycle. The materials and instructions for using the PERT website as well as the Excel spreadsheets are available on the website (<https://www.cmspert.org>).

PERT 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 PERT 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).
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 PERT 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 along with modified forms for States substituting MEQC data.

## 6-1 - Sampling Plan

The sampling plan, which must contain the information shown in Exhibit 6-1, is due by August 1<sup>st</sup> prior to the Federal fiscal year in which each State is participating in PERM. Note that for a State's first fiscal year under PERM, the number of cases to be sampled in each stratum each month must be consistent with those described in Section 3. The sampling plan should be signed and dated by an appropriate State official.

### Exhibit 6-1: Sampling Plan Content

Eligibility Sampling Plan for [State] Program: [Medicaid or CHIP] Fiscal Year [Year] Independent Entity [Agency]
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.
Active Cases
1. Description of the Universe for active cases.
2. Description of the strata for active cases.
3. Description of the following: <ul style="list-style-type: none"><li>• How the monthly sample will be drawn;</li><li>• How cases will be selected including the method used to randomly select cases;</li><li>• The number of cases that will be oversampled to account for fraud cases or other cases inappropriately included in the sample.</li></ul>
4. The quality control procedures that will be applied including procedures to ensure completeness of the population from which the sample is drawn.
5. Description of how records or claims and managed care payments associated with the cases sampled will be obtained.
6. Projected monthly sample size for each stratum.
7. 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.

#### 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.

### **6-2 - Monthly Sample Selections**

On completion of a sample for a given month, States must submit to CMS the list of cases sampled in each of the three strata for that month and the total number of cases in the universe for each stratum in that month. The same information must be submitted for negative cases, for which there is only one stratum. See Appendix J for the reporting form to be completed and submitted to CMS by the 15<sup>th</sup> day following the sample month and before the reviews begin.

### **6-3 - Detailed Active and Negative Case Review Findings**

Detailed eligibility findings for active and negative case reviews are recorded and are due 150 days of the end of each sample month for 100 percent of the cases reviewed for that month.

### **6-4 - Active Case Payment Review Findings**

The Active Case Payment Review Findings form is due within 210 days of the end of each sample month for 100 percent of the cases reviewed in that month.

### **6-5 - Medicaid and CHIP Summary Findings and Error Data**

As a result of its eligibility and payment reviews, States must report to CMS:

- State-specific case error data as well as payment error data for active cases;
- State-specific case error data for negative cases; and
- The number and payment amounts for undetermined cases.

## **Section 7 Calculating Medicaid and CHIP Eligibility Error Rates**

CMS will calculate the eligibility error rates for each program. A total of three error rates will be calculated for Medicaid and CHIP.

For active cases, the following error rates are calculated:

- A payment error rate; which is dollar weighted; and
- A case error rate.

For negative cases:

- A case error rate.

CMS will calculate the State and national error rates two ways:

- Undetermined included as payment errors.
- Undetermined excluded as correct or as payment errors.

States must report the number of cases for which a verification of eligibility could not be made during the review due to lack of documentation or other reasonable evidence.

The payments for services rendered during the sample month, the review month or the first 30 days of eligibility, as appropriate, for these cases must also be included in the payment reviews.

It should be noted that the PERM proposed rule makes the statistical contractor responsible for calculating eligibility error rates and that States will only be required to submit error and payment data. States are still responsible for calculating and submitting eligibility error rates until the PERM final rule is in place.

## Appendix A: Eligibility Review Process Timeline

PERM Eligibility Medicaid and CHIP Timeline													
		1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
August	September	October	November	December	January	February	March	April	May	June	July	August	September
FY 2008 States submit Sampling Plan Aug 1st	CMS works with States on sampling plans if needed	CMS approves sampling plan Oct 15th	Select October sample	Select November sample	Select December sample	Select January sample	Select February sample	Select March sample	Select April sample	Select May sample	Select June sample	Select July sample	Select August sample
			Submit October sample list Nov 15 <sup>th</sup>	Submit November sample list Dec 15 <sup>th</sup>	Submit December sample list Jan 15 <sup>th</sup>	Submit January sample list Feb 15 <sup>th</sup>	Submit February sample list Mar 15 <sup>th</sup>	Submit March sample list Apr 15 <sup>th</sup>	Submit April sample list May 15 <sup>th</sup>	Submit May sample list Jun 15 <sup>th</sup>	Submit June sample list Jul 15 <sup>th</sup>	Submit July sample list Aug 15 <sup>th</sup>	Submit August sample list Sep 15 <sup>th</sup>
			Begin October Eligibility Reviews	Begin November Eligibility Reviews	Begin December Eligibility Reviews	Begin January Eligibility Reviews	Begin February Eligibility Reviews	Begin March Eligibility Reviews	Begin April Eligibility Reviews	Begin May Eligibility Reviews	Begin June Eligibility Reviews	Begin July Eligibility Reviews	Begin August Eligibility Reviews
							October eligibility reviews due Mar 31st & collect October claims	November eligibility reviews due Apr 30th & Collect November Claims	December eligibility reviews due May 31st & Collect December Claims	January eligibility reviews due Jun 30th & Collect January Claims	February eligibility reviews due Jul 31st & Collect February Claims	March eligibility reviews due Aug 31st & Collect March Claims	April eligibility reviews due Sep 30th & Collect April Claims
									Complete October Payment Reviews May 15 <sup>th</sup>	Complete November Payment Reviews Jun 15 <sup>th</sup>	Complete December Payment Reviews Jul 15 <sup>th</sup>	Complete January Payment Reviews Aug 15 <sup>th</sup>	Complete February Payment Reviews Sep 15 <sup>th</sup>

## Appendix A: Eligibility Review Process Timeline

Following Fiscal Year—PERM Medicaid and CHIP Eligibility Timeline: Continuation													
August	September	October	November	December	January	February	March	April	May	June	July	August	September
		Submit September sample list Oct 15 <sup>th</sup>									Error Rates and findings due 7/1 <sup>st</sup>		
		Begin September Eligibility reviews								Calculate State Case and Payment Error rates and complete findings			
		May eligibility reviews due Oct 31 <sup>st</sup> & Collect May Claims	June eligibility reviews due Nov 30 <sup>th</sup> & Collect June Claims	July eligibility reviews due Dec 31 <sup>st</sup> & Collect July Claims	August eligibility reviews due Jan 31 <sup>st</sup> & Collect August Claims	September eligibility reviews due Feb 28 <sup>th</sup> & Collect September Claims							
		Complete March Payment Reviews Oct 15 <sup>th</sup>	Complete April Payment Reviews Nov 15 <sup>th</sup>	Complete May Payment Reviews Dec 15 <sup>th</sup>	Complete June Payment Reviews Jan 15 <sup>th</sup>	Complete July Payment Reviews Feb 15 <sup>th</sup>	Complete August Payment Reviews Mar 15 <sup>th</sup>	Complete September Payment Reviews Apr 15 <sup>th</sup>					

## 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's name has been referred to the State Fraud and Abuse Control or similar investigation unit and the unit is currently actively pursuing an investigation to determine whether the beneficiary committed fraud.

**Agency:** For purposes of the PERM eligibility reviews, the agency that performs the Medicaid and CHIP eligibility reviews under PERM and excludes the State agency as defined below.

**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 (spenddown) 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 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):** A program authorized and funded under Title XXI of the Social Security Act. Federal regulations governing this program are at 42 CFR Part 457.

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

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

## Appendix B: Glossary

**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 under Title XIX of the Social Security Act (the Act) that provides medical care to people with low incomes and limited resources.

**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.

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

## **Appendix B: Glossary**

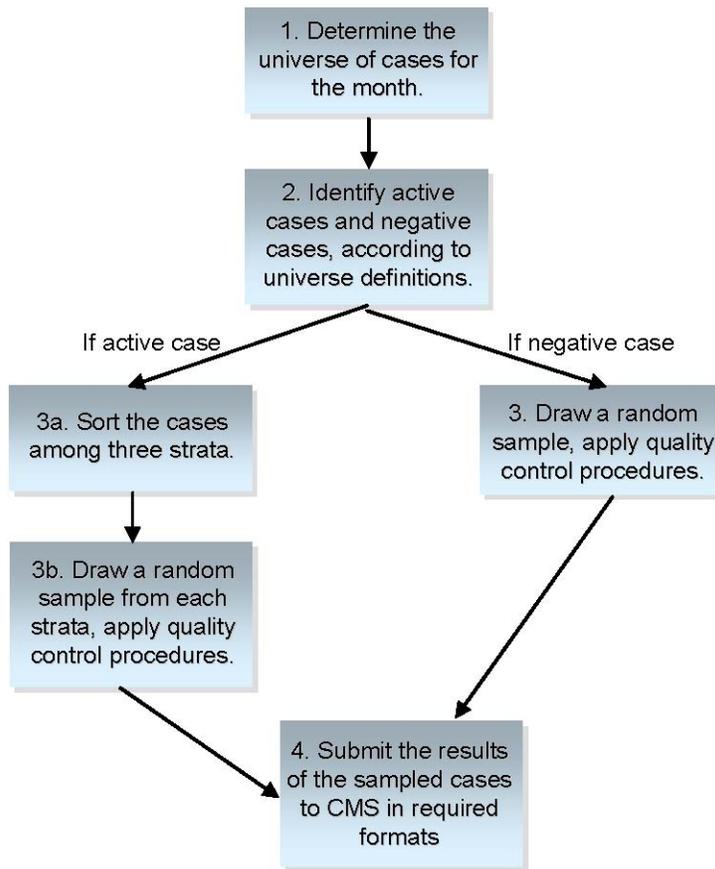
**Sample month:** The month the State selects a case from the sampling universe for an eligibility review.

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

**Technical error:** Errors in eligibility which 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 4-3.

**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 Process



## Appendix D: Active 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.

### *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”).

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

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

$\pi_i$  = 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,

## Appendix D: Active Case Eligibility Sample Size

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

Assume,

$$E(P_{ij}) = \mu_{P_i}$$

$$\text{Var}(P_{ij}) = \sigma_{P_i}^2$$

Now,

$$\begin{aligned} \text{Var}\left(\sum_j X_{ij} P_{ij}\right) &= \text{Var}\left(E\left(\sum_j X_{ij} P_{ij} \mid X_{ij}\right)\right) + E\left(\text{Var}\left(\sum_j X_{ij} P_{ij} \mid X_{ij}\right)\right) \\ &= \text{Var}\left(\sum_j X_{ij} \mu_{P_i}\right) + E\left(\sum_j X_{ij}^2 \sigma_{P_i}^2\right) \\ &= \mu_{P_i}^2 \sum_j \text{Var}(X_{ij}) + \sigma_{P_i}^2 \sum_j E(X_{ij}^2) \\ &= \mu_{P_i}^2 n_i \sigma_{X_i}^2 + \sigma_{P_i}^2 n_i (\sigma_{X_i}^2 + \mu_{X_i}^2) \\ &= n_i (\mu_{P_i}^2 \sigma_{X_i}^2 + \sigma_{P_i}^2 \sigma_{X_i}^2 + \sigma_{P_i}^2 \mu_{X_i}^2) \end{aligned}$$

Then,

$$\begin{aligned} \text{Var}(\hat{R}) &= \frac{\sum_i w_i^2 \text{Var}\left(\sum_j X_{ij} P_{ij}\right)}{P^2} \\ &= \frac{\sum_i \frac{N_i^2}{n_i^2} n_i (\mu_{P_i}^2 \sigma_{X_i}^2 + \sigma_{P_i}^2 \sigma_{X_i}^2 + \sigma_{P_i}^2 \mu_{X_i}^2)}{P^2} \end{aligned}$$

By Neyman-Pearson optimal allocation,

$$n_i = \frac{P_i}{\sum_i P_i} n$$

## Appendix D: Active Case Eligibility Sample Size

where,  $P_i$  = Total payments for the i-th stratum ( $\sum_i P_i = P$ )

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

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

$$\begin{aligned} Var(\hat{R}) &= \frac{\sum_i \frac{N_i^2 P}{P_i n} \xi_i}{P^2} \text{ (substituting for } n_i) \\ &= \frac{1}{nP} \sum_i \frac{N_i^2}{P_i} \xi_i = \sigma_{\hat{R}}^2 \end{aligned}$$

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

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

The margin of error,  $d$ , is thus

$$\begin{aligned} d &= z_{\alpha/2} \sigma_{\hat{R}} \\ \Rightarrow d^2 &= z_{\alpha/2}^2 \sigma_{\hat{R}}^2 \\ &= z_{\alpha/2}^2 \frac{1}{nP} \sum_i \frac{N_i^2}{P_i} \xi_i \end{aligned}$$

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

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

To get an estimate for the sample size, it is important to have estimates for  $\xi_i$ , which requires knowledge of variance for payments in each stratum ( $\sigma_p^2$ ), the chance of belonging to a stratum ( $\pi_i$ , 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.

## Appendix D: Active Case Eligibility Sample Size

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

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

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

$$K = \frac{\sigma_p}{\mu_p}$$

$$\begin{aligned} \text{Then, } \xi &= \mu_p^2 \sigma_x^2 + \sigma_p^2 \sigma_x^2 + \sigma_p^2 \mu_x^2 \\ &= \mu_p^2 \sigma_x^2 + K^2 \mu_p^2 \sigma_x^2 + K^2 \mu_p^2 \mu_x^2 \\ &= \mu_p^2 (\sigma_x^2 + K^2 \sigma_x^2 + K^2 \mu_x^2) \\ &= \mu_p^2 ((1 + K^2) \sigma_x^2 + K^2 \mu_x^2) \end{aligned}$$

For a simple random sample,

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

( $\pi$  can also be interpreted as the error rate).

Hence,

$$\xi = \mu_p^2 ((1 + K^2) \pi (1 - \pi) + K^2 \pi^2)$$

Note: An estimate for  $\mu_p$  is,  $\hat{\mu}_p = \bar{P}$ .

Hence, for a simple random sample

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

## Appendix D: Active Case Eligibility Sample Size

$$\begin{aligned} &= \frac{z_{\alpha/2}^2}{d^2} \frac{1}{\bar{P}^2} \mu_p^2 \left( (1 + K^2) \pi (1 - \pi) + K^2 \pi^2 \right) \\ &= \frac{z_{\alpha/2}^2}{d^2} \left( (1 + K^2) \pi (1 - \pi) + K^2 \pi^2 \right) \text{(substituting } \hat{\mu}_p = \bar{P} \text{)} \end{aligned}$$

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

$$\alpha = 0.05$$

$$d = 0.03 \text{ (3.0 percentage points)}$$

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

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

and

## Appendix D: Active Case Eligibility Sample Size

$$n_i = \frac{P_i}{\sum_i P_i} n$$

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),  $\pi$  is the probability a case's eligibility is incorrect,  $z$  is the standard normal value,  $\alpha$  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:

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

### ***Method for Drawing Monthly Sample***

Initially, for FY 2007, 2008 and 2009, the total annual sample size for each program was 504 cases for the active case payment error rate, unless the State had an approved sampling plan with a reduced sample size based on the finite population correction.

There are two primary methods for States to use to draw a random sample: simple random sampling or the "skip" factor method. Using simple random sampling, assign each case in a stratum an integer from 1 to  $N$ , where  $N$  is the number of cases in the stratum 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 that stratum. For example, if the number of cases in the stratum universe is 1,000, and a sample of 22 is needed, assign each case an integer from 1 to 1,000. Then generate 22 random

## **Appendix D: Active Case Eligibility Sample Size**

integers between 1 and 1,000, without replacement. Cases that were assigned one of the randomly generated integers would be included in the sample.

Using the “skip” factor method, divide the number of cases in the stratum universe by the required sample size for that stratum. 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 stratum 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 stratum 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 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. However, as discussed later in this section, States may want to draw an oversample in case any problems are discovered in the sample (active beneficiary fraud, etc.). When using the “skip” factor method of sampling, after the sample is drawn, the State will need to randomly select the cases which will be considered the oversample cases (taking the first two or last two cases is not random).

## Appendix E: MEQC & PERM Sampling and Review Differences

Provision	“Traditional MEQC”	PERM
<b>Administrative Period</b>	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.
<b>Client Contact</b>	Home visits for client interviews.	Not always necessary to contact beneficiary if case record has all information to make a review decision.
<b>Error Dollar Tolerance</b>	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.
<b>Error Rate Calculation</b>	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.
<b>Exclusions</b>	From the universe: <ul style="list-style-type: none"> <li>• Those cases for which Medicaid eligibility was determined by SSA in 1634</li> </ul>	From the universe: <ul style="list-style-type: none"> <li>• All cases that were denied or terminated;</li> <li>• Cases under active fraud investigation as defined in</li> </ul>

## Appendix E: MEQC & PERM Sampling and Review Differences

	<p>contract States;</p> <ul style="list-style-type: none"> <li>• Cases eligible for Medicaid based on title IV-E adoption or foster care;</li> <li>• Cases funded 100 percent by the Federal Government; and</li> <li>• Retroactively eligible cases.</li> <li>• Cases that have been approved for Medicaid or CHIP using the States’ “Express Lane” eligibility option according to Section 1902(e)(13) of the Social Security Act.</li> </ul> <p>From review:</p> <ul style="list-style-type: none"> <li>• Beneficiary does not cooperate;</li> <li>• Beneficiary cannot be located;</li> <li>• Beneficiary moved out of State;</li> <li>• Beneficiary has requested an appeal of an eligibility determination.</li> </ul>	<p>Appendix B;</p> <ul style="list-style-type: none"> <li>• State-only funded cases for which the State receives no Federal matching dollars;</li> <li>• Cases that have been approved for Medicaid or CHIP using the States’ “Express Lane” eligibility option according to Section 1902(e)(13) of the Social Security Act.</li> <li>• 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</li> <li>• For Medicaid only, adoption assistance and foster care cases under Title IV-E.</li> </ul> <p>From review:</p> <p>None</p>
<p><b>Incomplete Reviews</b></p>	<p>Cases can be dropped from review if:</p> <ul style="list-style-type: none"> <li>• Client cannot be located.</li> </ul>	<p>Information not retrieved for the PERM review could result in an “undetermined” finding.</p>

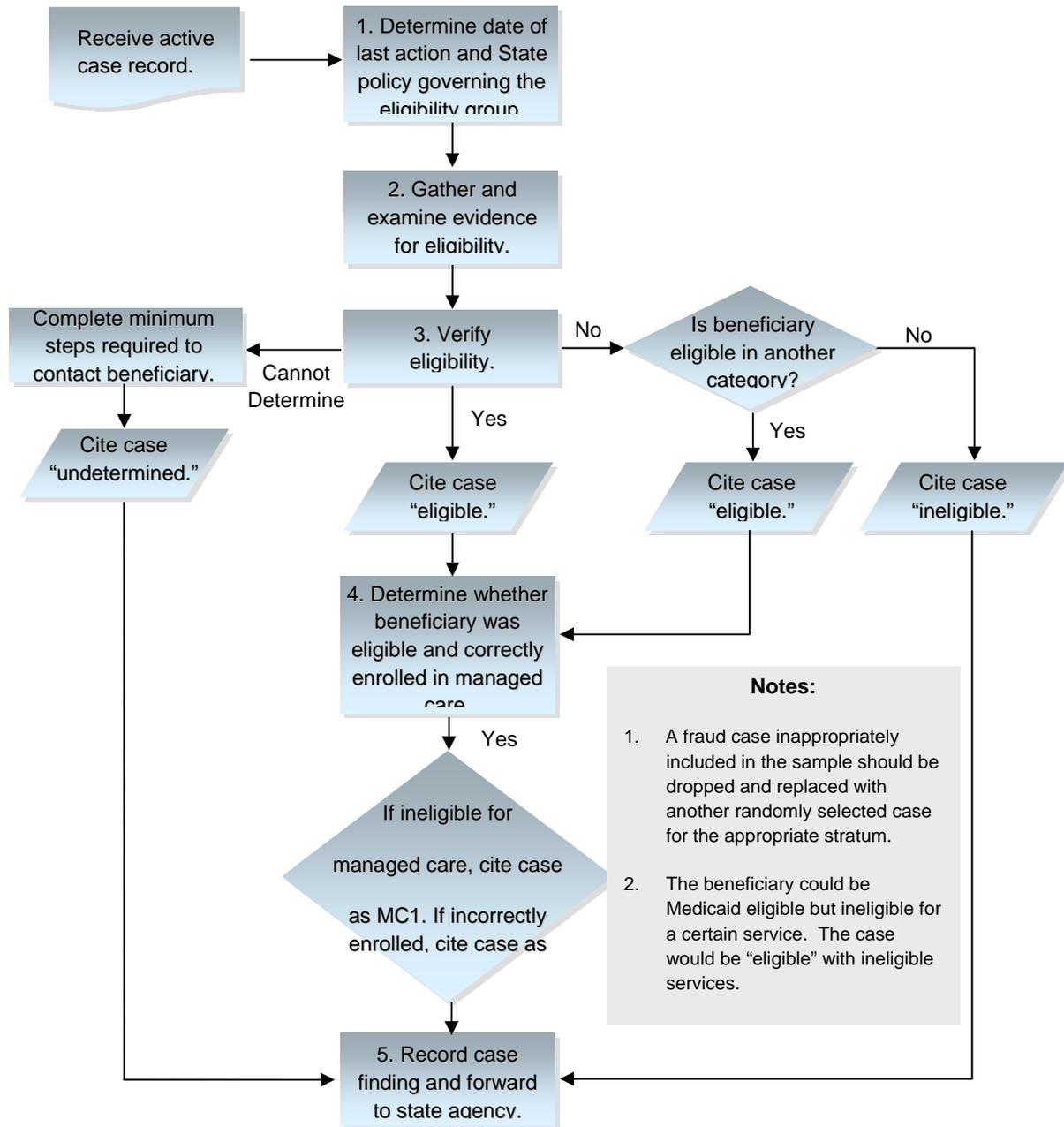
## Appendix E: MEQC & PERM Sampling and Review Differences

	<ul style="list-style-type: none"> <li>• Client does not respond to requests for information.</li> <li>• Client has moved out of State.</li> </ul>	
<b>Precision</b>	95% confidence with +/- 2% precision	95% confidence with +/- 3% precision
<b>Recovery of Improper Payments</b>	Disallowance provision apply for States with improper payments over the 3% National Standard.	Recoveries for Medicaid and CHIP for improper payments found in Fee for Service and Managed Care. Since disallowance provisions apply for eligibility improper payments under Medicaid and title XXI Medicaid expansion, PERM only recovers eligibility improper payments for CHIP stand alone.
<b>Review Month</b>	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.
<b>Sample Size</b>	Varies by State: Minimum sample sizes for each State in MEQC manual.	Base year sample size is 504 active cases. Can be reduced in future cycles using prior year(s) data.
<b>Sampling Unit</b>	Assistance unit; Family unit; "case"	Individual beneficiary
<b>Source of Errors</b>	MEQC identifies Agency errors vs. Client errors	PERM considers all eligibility errors State errors.
<b>Stratification:</b>	Prior to 1996, States stratified Medicaid Only cases and AFDC-Medicaid cases.	Cases are stratified by (1) applications, (2) redeterminations and (3) all other cases.

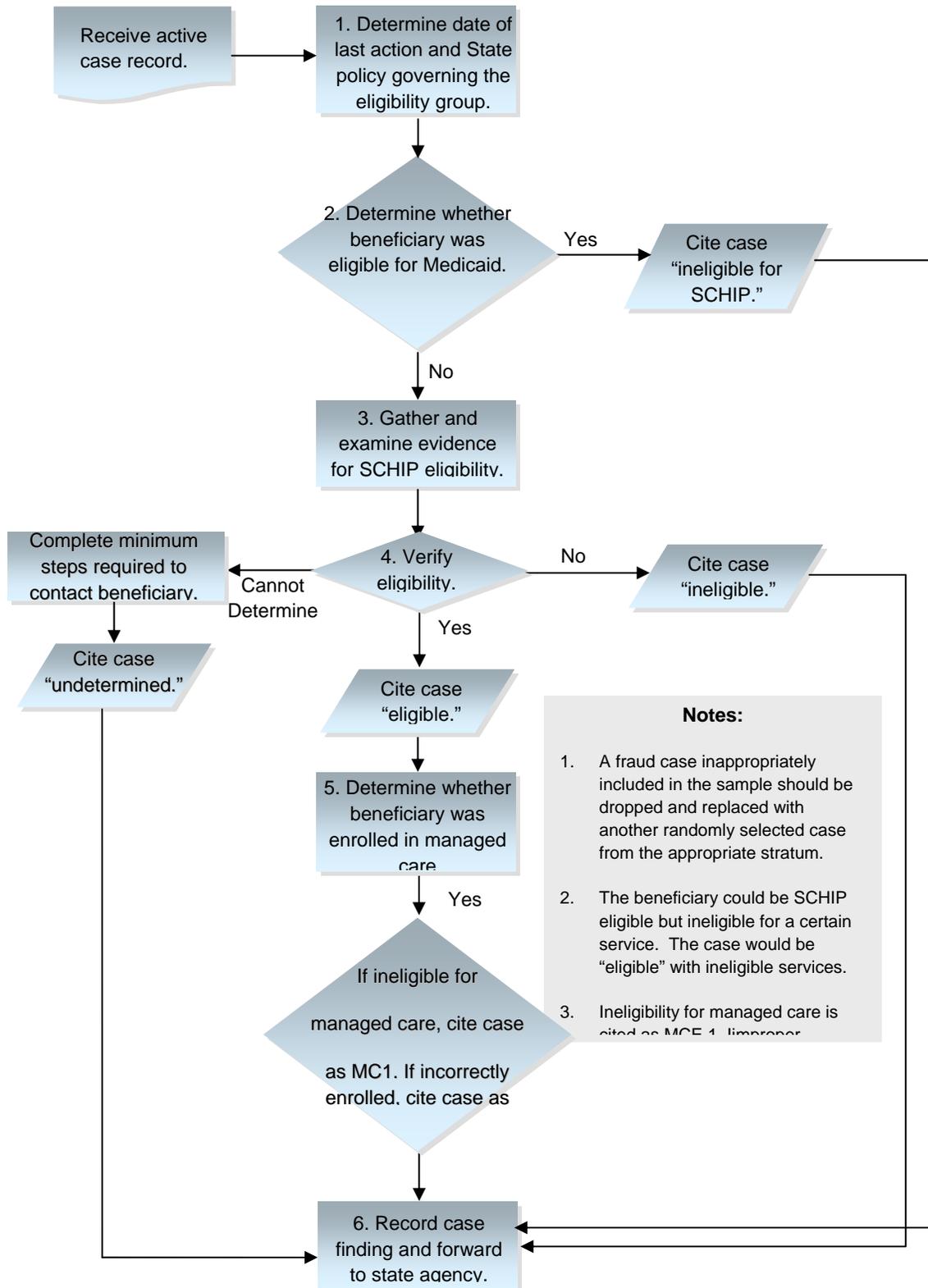
## Appendix E: MEQC & PERM Sampling and Review Differences

	<p>Post 1996, this stratification no longer required due to the separation of AFDC and Medicaid.</p> <p>States without a Section 1634 agreement with The Social Security Administration should stratify Medicaid cases and SSI cash cases, unless waived with CMS approval.</p>	
<p><b>Required Verification</b></p>	<p>Independently verify actual circumstances.</p> <p>Client interviews and home visits required.</p>	<p>Review case record contents.</p> <p>Independently verify eligibility criteria where evidence is either missing or outdated (more than 12 months old) and likely to change.</p> <p>New self declaration statement required for CHIP if State has self declaration policies in State Plan.</p>

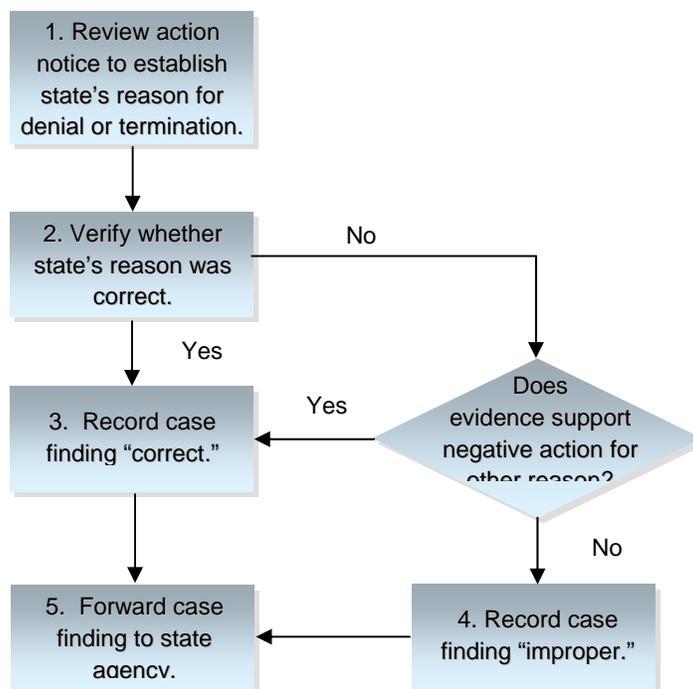
## Appendix F: Medicaid Active Case Review Process



# Appendix G: CHIP Active Case Review Process



## Appendix H: Medicaid and CHIP Negative Case Review Process



## 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 estimated 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 combine 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 to 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.

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  $l$ th case in the  $k$ th stratum,

$p_{kl}$  represents the payment on the  $l$ th case in the  $k$ th 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,

## Appendix I: Calculating Medicaid and CHIP Eligibility Error Rates

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

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

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

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*

## Appendix I: Calculating Medicaid and CHIP Eligibility 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

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

## Appendix I: Calculating Medicaid and CHIP Eligibility Error Rates

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

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

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

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

## Appendix J: Reporting Forms

<b>Monthly Sample Selection List</b>					
<b>A. State</b>					
<b>B. Date</b>					
<b>C. Program</b>					
<b>D. Sample Month</b>					
<b>E. Number of cases in universe that month</b>	<b>Stratum 1 Applications</b>	<b>Stratum 2 Redeterminations</b>	<b>Stratum 3 All Other Cases</b>	<b>Negative Cases</b>	<b>Express Lane Cases</b>
<b>F.</b>	<b>Case/Beneficiary ID</b>	<b>Case/Beneficiary ID</b>	<b>Case/Beneficiary ID</b>	<b>Case/Beneficiary ID</b>	
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					
13)					
14)					
15) Oversample					
16) Oversample					
17) Oversample					

## Appendix J: Reporting Forms

This form is due to CMS on the 15th day of the month after the sample month and must be submitted before eligibility reviews begin.

### 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 Columbia. The Territories are excluded from the PERM program.

### Line B: Date

Enter the date that the Monthly Sample Selection form is being submitted to CMS (e.g. February 15, 2010). If this form is being resubmitted, enter the date of the resubmission.

### Line C: Program

Enter the program for which the Monthly Sample Selection List applies (e.g. Medicaid or CHIP).

### Line D: Sample Month

Enter the month for which the sample was drawn from the universe, e.g. January. “Universe” refers to the total number of cases in the sample month. The universe will be unique for each month.

### Line E: Number of Cases in the Universe for the Sample Month

Enter the total number of active cases and negative cases in the universe during the sample month. Enter the total number of express lane cases that are excluded from the PERM universe. The active case 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 negative case universe is the total number of cases that have either been denied based on a completed application or terminated based on a completed redetermination in the given sample month. The express lane total includes the number of individuals excluded from the PERM universe due to being enrolled in Medicaid or CHIP using Express Lane Eligibility. Leave this entry blank if your State has not implemented Express Lane Eligibility

- **Stratum 1 – Applications:** A case constitutes an “application” for the sample month if the State took an action to grant eligibility in that month based on a completed application.
- **Stratum 2 – Redeterminations:** A case constitutes a “redetermination” for the sample month if the State took an action to continue eligibility in the sample month based on a completed redetermination.

## Appendix J: Reporting Forms

- **Stratum 3 – All Other Cases:** All other cases (properly included in the universe but do not meet the Strata 1 or 2 criteria) that are on the program in the sample month are placed in Stratum 3.
- **Negative Cases:** A negative case contains information on a beneficiary who completed an application for benefits and the State denied the application or who completed the redetermination process but whose program benefits were terminated by the State.
- **Express Lane Cases:** Express lane cases are cases that have been approved for Medicaid or CHIP using the States' Express Lane Eligibility option in accordance with section 1902(e)(13) of the Social Security Act. These cases must be excluded from the PERM eligibility universe.

### Line F: Case/Beneficiary Identification (ID)

“Case” refers to an individual beneficiary and, for PERM purposes, is not a household or family unit. In this row, enter the case identification (ID) or beneficiary ID, whichever is the custom of the State, which correlates with the case reported as sampled on the Monthly Sample Selection List for the sample month.

For each case selected for the sample of active cases, list the case ID in the column for the respective stratum (e.g. Stratum 1, Stratum 2, or Stratum 3). For each case selected for the sample of negative cases, list the case ID in the Negative Cases column. The Express Lane Cases column should be left blank, as no express lane cases should be sampled.

**Oversample:** Include any cases selected as oversample cases in these rows. Negative cases have a maximum of 3 oversample cases.

## Appendix J: Reporting Forms

### Detailed Active Case Review Findings

<b>A. State</b>					
<b>B. Date</b>					
<b>C. Program</b>					
<b>D. Sample Month</b>					
<b>E. Case/Beneficiary ID</b>	<b>Review Month</b>	<b>Date of Dropped Case</b>	<b>Stratum 1, 2, or 3</b>	<b>Review Finding</b>	<b>Cause of Error Example: excess income, non-resident</b>
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					
13)					
14)					
15)					
16)					
17)					
18)					
19)					
20)					
21)					
22)					
23)					
24)					
25)					
26)					
27)					

## **Appendix J: Reporting Forms**

This form is due within 150 days from the end of each sample month (i.e. if the sample month is January, the Detailed Active Case Review Findings form is due on June 30, which is 150 days from January 31).

### **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 Columbia. The Territories are excluded from the PERM program.

### **Line B: Date**

Enter the date that the Detailed Active Case Review Findings form is being submitted to CMS (e.g. June 15, 2010). If this form is being resubmitted, enter the date of resubmission.

### **Line C: Program**

Enter the program for which the monthly Detailed Active Case Review Findings form applies (e.g. Medicaid or CHIP).

### **Line D: Sample Month**

Enter the month for which the sample was drawn from the universe. “Universe” refers to the total number of cases in the sample month. The case universe will be unique for each month.

### **Line E: Case/Beneficiary Identification (ID)**

“Case” refers to an individual beneficiary and, for PERM purposes, is not a household or family unit. In this row, enter the case identification (ID) or beneficiary ID, whichever is the custom of the State, which correlates with the case reported as sampled on the monthly sample selection list for the same sample month.

Add rows if the number of cases in the active case sample for the month being reported exceeds the number of rows provided.

- **Review Month**

Enter the review month for which eligibility was verified (the review month is not necessarily the same as the sample month). Generally, the review month is the same as the sample month for cases in Strata 1 and 2 because, for PERM purposes, the review month is when the State’s last action occurred. However, in Stratum 3, the timeframe for verifying eligibility could differ. Generally, eligibility would be verified as of the month of the State’s last action; but if that action occurred more than 12 months prior to the sample month, then eligibility is reviewed as of

## Appendix J: Reporting Forms

the sample month. In the “Review Month” column, enter the month in which eligibility was verified, i.e. either the review month or the sample month, as appropriate to each case.

- **Date of Dropped Case**

A State can only drop and replace a case from the PERM eligibility sample for the following reasons:

1. A case should have been excluded from the sampling universe but was inadvertently included in the universe and sampled or
2. A case is found to be under active beneficiary fraud investigation.

“Active beneficiary fraud investigation” is defined as a beneficiary’s name has been referred to the State Fraud and Abuse Control or similar investigation unit and the unit is currently actively pursuing an investigation to determine whether the beneficiary committed fraud.

States should exclude these cases from the universe. However, if a State cannot exclude these cases from the universe, the State can drop these cases if they appear in the sample.

Do not enter a review finding for dropped cases.

- **Stratum**

Enter the number of the eligibility stratum for the case (e.g. Stratum 1). The strata are as follows:

- o **Stratum 1 – Applications:** A case constitutes an “application” for the sample month if the State took an action to grant eligibility in that month based on a completed application.
- o **Stratum 2 – Redetermination:** A case constitutes a “redetermination” for the sample month if the State took an action to grant eligibility in that month based on a completed redetermination.
- o **Stratum 3 – All Other Cases:** All other cases (properly included in the universe but do not meet the Strata 1 or 2 criteria) that are on the program in the sample month are placed in Stratum 3.

- **Review Finding**

Enter the letter code for the review finding (e.g. MCE1) for each case. The eight review findings are defined as follows:

- o **E – Eligible:** An individual beneficiary meets the State’s categorical and financial criteria for receipt of benefits under the program

## Appendix J: Reporting Forms

- o **EI – Eligible with Ineligible Services:** An individual beneficiary meets the State’s categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs but was not eligible to receive particular services. An example of “eligible with ineligible services” would be a person eligible under the medically needy group who received services not provided to the medically needy group. Another example would be a person enrolled as a Qualified Medicare Beneficiary (QMB), but upon further review is determined to be eligible as a Specified Low-Income Medicare Beneficiary (SLMB).
- o **NE – Not Eligible:** An individual beneficiary is receiving benefits under the program but does not meet the State’s categorical and financial criteria for the month eligibility is being verified.
- o **U – Undetermined:** A beneficiary case subject to a Medicaid or CHIP eligibility review under PERM for which a definitive eligibility review decision could not be made.
- o **L/O – Liability Overstated:** The beneficiary paid too much towards his liability amount or cost of institutional care and the State paid too little; or a beneficiary’s premium payment was miscalculated and based on this miscalculation the State paid too little towards a managed care organization (MCO) capitation payment on his/her behalf.
- o **L/U – Liability Understated:** The beneficiary paid too little towards his liability amount or cost of institutional care and the State paid too much; or a beneficiary’s premium payment was miscalculated and based on this miscalculation the State paid too much towards an MCO capitation payment on his/her behalf.
- o **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.
- o **MCE2 – Managed care error, 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.

**Note:** Some review findings will not be definitive until the payment reviews are conducted.

Leave this column blank if a case is dropped or oversample cases are not used.

- **Cause of Error:** Enter the cause of the error for cases not eligible for the program. Explanations for this column are not standardized but should reflect the State’s findings that caused the case to be in error. **Do not use State-specific codes or abbreviations.**

## Appendix J: Reporting Forms

### Detailed Negative Case Review Findings

<b>A. State</b>			
<b>B. Date</b>			
<b>C. Program</b>			
<b>D. Sample Month</b>			
<b>E. Case/Beneficiary ID</b>	<b>D – Denial T – Termination</b>	<b>Review Finding</b>	<b>Cause of Error</b>
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			
21)			
22)			
23)			
24)			
25)			

## Appendix J: Reporting Forms

This report is due within 150 days from the end of the sample month (i.e. if the sample month is January, the form is due on June 30, which is 150 days from January 31).

### 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 Columbia. The Territories are excluded from the PERM program.

### Line B: Date

Enter the date that the Detailed Negative Case Review Findings form is being submitted to CMS (e.g. June 15, 2010). If this form is being resubmitted, enter the date of resubmission.

### Line C: Program

Enter the program for which the monthly Detailed Negative Case Review Findings form applies (e.g. Medicaid or CHIP).

### Line D: Sample Month

Enter the month for which the sample was drawn from the universe. “Universe” refers to the total number of cases in the sample month. The case universe will be unique for each month.

### Line E: Case/Beneficiary Identification (ID)

“Case” refers to an individual beneficiary and, for PERM purposes, is not a household or family unit. In this row, enter the case ID or beneficiary ID, whichever is the custom of the State, which correlates with the case reported as sampled on the Monthly Sample Selection List for the sample month.

Add rows if the number of cases in the negative case sample for the month being reported exceeds the number of rows provided.

- **Denial or Termination**

- o **Denial:** Means an application was completed by the beneficiary but was rejected for not meeting eligibility requirements.

- o **Termination:** Means an existing beneficiary completed the redetermination process but no longer meets eligibility requirements and is therefore not eligible for the program.

Enter “D” if the case was a denial. Enter “T” if the case was a termination.

- **Review Finding**

## Appendix J: Reporting Forms

Enter the letter code for the review finding. The three review findings are defined as follows:

- o **C – Correct:** The negative case was properly denied or terminated by the State.
- o **ID – Improper Denial:** The application for program benefits was denied by the State for not meeting the categorical and/or financial eligibility requirements but upon review is found to be eligible.
- o **IT – Improper Termination:** Based on a completed redetermination, the State determines an existing beneficiary no longer meets the program’s categorical and/or financial eligibility requirements and is terminated but upon review is found to still be eligible.
- **Cause of Error**

Enter the cause of the error. Explanations for this column are not standardized but should reflect the State’s eligibility determination policies. **Do not use State-specific codes or abbreviations.**

## Appendix J: Reporting Forms

### Detailed Payment Review Findings Form

<b>A. State</b>						
<b>B. Date</b>						
<b>C. Program</b>						
<b>D. Sample Month</b>						
<b>E. Case/Beneficiary Identification (ID)</b>	<b>Date of Dropped Case</b>	<b>Stratum 1, 2 or 3</b>	<b>Review Finding</b>	<b>Payment Amount Correct</b>	<b>Payment Amount in Error</b>	<b>Payment Amount Undetermined</b>
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						
9)						
10)						
11)						
12)						
13)						
14)						
15)						
16)						
17)						
18)						
19)						
20)						
21)						
22)						
23)						
24)						
25)						
26)						
27)						
28)						

## Appendix J: Reporting Forms

This form is due 210 days from the end of the sample month (i.e. the payment review for the sample month of January is due on August 31st, which is 210 days from January 31).

### 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 Columbia. The Territories are excluded from the PERM program.

### Line B: Date

Enter the date that the Detailed Payment Review Findings form is being submitted to CMS (e.g. June 15th, 2010). If this form is being resubmitted, enter the date of resubmission.

### Line C: Program

Enter the program for which the Detailed Payment Review Findings form applies (e.g. Medicaid or CHIP).

### Line D: Sample Month

Enter the month for which the sample was drawn from the universe. “Universe” refers to the total number of cases in the sample month. The case universe will be unique for each month.

### Line E: Case/Beneficiary Identification (ID)

“Case” refers to an individual beneficiary and, for PERM purposes, is not a household or family unit. In this row, enter the case ID or beneficiary ID, whichever is the custom of the State, which correlates with the case reported as sampled on the Monthly Sample Selection List for the sample month.

Add rows if the number of cases in the active case sample for the month being reported exceeds the number of rows provided.

**Note:** Include all sampled cases in this table, not just those with payment errors.

- **Date of Dropped Case**

A State can only drop and replace a case from the PERM eligibility sample for the following reasons:

1. A case should have been excluded from the sampling universe but was inadvertently included in the universe and sampled, or
2. A case is found to be under an active beneficiary fraud investigation.

## Appendix J: Reporting Forms

“Active beneficiary fraud investigation” is defined as a beneficiary’s name has been referred to the State Fraud and Abuse Control or similar investigation unit and the unit is currently actively pursuing an investigation to determine whether the beneficiary committed fraud.

States should exclude these cases from the universe. However, if a State cannot exclude these cases from the universe, the State can drop these cases if they appear in the sample.

Do not enter a review finding for dropped cases.

- **Stratum**

Enter the number of the eligibility stratum for the case (e.g. Stratum 1). The strata are as follows.

- o **Stratum 1 – Applications:** A case constitutes an “application” for the sample month if the State took an action to grant eligibility in that month based on a completed application.

- o **Stratum 2 – Redeterminations:** A case constitutes a “redetermination” for the sample month if the State took an action to continue eligibility in the sample month based on a completed redetermination.

- o **Stratum 3 – All Other Cases:** All other cases (properly included in the universe but do not meet the Strata 1 or 2 criteria) that are on the program in the sample month are placed in Stratum 3.

- **Review Finding**

Enter the letter code for the review finding (e.g. MCE1) for each case. The eight review findings are defined as follows:

- o **E – Eligible:** An individual beneficiary meets the State’s categorical and financial criteria for receipt of benefits under the program.

- o **EI – Eligible with Ineligible Services:** An individual beneficiary meets the State’s categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs but was not eligible to receive particular services. An example of “eligible with ineligible services” would be a case where a person is eligible under the medically needy group who received services not provided to the medically needy group. Another example would be a person enrolled as a Qualified Medicare Beneficiary (QMB), but upon further review is determined to be eligible as a Specified Low-Income Medicare Beneficiary (SLMB).

- o **NE – Not Eligible:** An individual beneficiary is receiving benefits under the program but does not meet the State’s categorical and financial criteria for the month eligibility is being verified.

## Appendix J: Reporting Forms

- o **U – Undetermined:** An individual beneficiary subject to a Medicaid or CHIP eligibility review under PERM for which a definitive eligibility review decision could not be made.
- o **L/O – Liability Overstated:** The beneficiary paid too much toward his liability amount or cost of institutional care and the State paid too little; or a beneficiary’s premium payment was miscalculated, and based on this miscalculation the State paid too little towards a managed care organization (MCO) capitation payment on his/her behalf.
- o **L/U – Liability Understated:** The beneficiary paid too little towards his liability amount or cost of institutional care and the State paid too much; or a beneficiary’s premium payment was miscalculated and based on this miscalculation the State paid too much towards an MCO capitation payment on his/her behalf.
- o **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.
- o **MCE2 – Managed care error, 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.

Leave this column blank if a case is dropped or oversample cases are not used.

- **Payment Amount Correct** – A correct payment amount is a payment to a provider, insurer, or managed care organization based on the beneficiary’s eligibility for the program and for the services received under the coverage group under which the beneficiary is eligible as defined in the State’s plan.
  - o For fee for service cases, enter the total amount of dollars paid for the beneficiary based on claims for services rendered at any time during the first 30 days of eligibility, in the sample month or in the spenddown period (if appropriate) which are paid by the end of the fourth month after the review month (or sample month for cases in Stratum 3).
  - o For managed care cases, enter the capitated amount paid for the case. All managed care payments made for coverage in the review month (for Strata 1 and 2 cases) and the sample month (for Stratum 3 cases) are included regardless of the actual payment date so long as the payment dates fall within the review month (for cases in Strata 1 and 2) or sample month and are paid by the end of the fourth month after the review month or sample month.
  - o For States that offer fee for service “carve out” services alongside managed care coverage, the capitation payment with the additional fee for service payments should be included in the payment review.

## Appendix J: Reporting Forms

o For States that accept premium payments from beneficiaries for coverage, the premium payment from the beneficiary should not be included in the payment review, but instead considered to determine whether the State portion of a capitation payment paid to the appropriate MCO was in the correct amount.

Enter the portion of the payments, in whole or in part as appropriate, that were correct for each sampled case. Do not enter payment amounts for cases that are dropped.

Place a zero in this column if there is no correct payment amount.

• **Payment Amount in Error** – Enter the amount of payment that is in error based on the beneficiary's:

- o Ineligibility for services received,
- o Ineligibility for the program.
- o Liability overstated or understated,
- o Ineligibility for managed care, or
- o Eligibility for managed care but enrollment in the wrong managed care plan.

Enter the portion of the 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.

• **Payment Amount Undetermined** – Enter the amount of payment that is 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.

Leave payment columns blank if a case is dropped or oversample cases are not used.

## Appendix J: Reporting Forms

### Summary Findings Form

<b>A. State</b>										
<b>B. Date</b>										
<b>C. Program</b>										
	<b>Number of Cases in Universe</b>	<b>Number of Cases Sampled</b>	<b>Number of Cases Dropped from Sample</b>	<b>Number of Cases Correct</b>	<b>Number of Cases Incorrect</b>	<b>Number of Cases Undetermined</b>	<b>Total Dollars Paid</b>	<b>Total Dollars Correct</b>	<b>Total Dollars in Error</b>	<b>Total Dollars Undetermined</b>
<b>D. Active</b>										
<b>Stratum 1</b>										
<b>Stratum 2</b>										
<b>Stratum 3</b>										
<b>E. Negative</b>										
<b>Denials</b>										
<b>Terminations</b>										
<b>F. Totals</b>										

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

## Appendix J: Reporting Forms

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 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 Columbia. 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 equal to the sum of Strata 1, 2 and 3. An active case is a case containing information on beneficiaries who were enrolled in the program in the sample month.

**Stratum 1—Applications:** A case constitutes an “application” for the sample month if the State took an action to grant eligibility in that month based on a completed application.

Enter the total number of active cases in Stratum 1, Applications, sampled for the fiscal year.

**Stratum 2—Redeterminations:** A case constitutes a “redetermination” for the sample month if the State took an action to continue eligibility in the sample month based on a completed redetermination.

Enter the total number of active cases in Stratum 2, Redeterminations, sampled for the fiscal year.

**Stratum 3—All Other Cases:** All other cases (properly included in the universe but do not meet the Strata 1 or 2 criteria) that are on the program in the sample month are placed in Stratum 3.

Enter the total number of active cases in Stratum 3, All Other Cases, sampled for the fiscal year.

### Line E: Negative

A negative case is a case where a beneficiary completed an application for benefits and the State denied the application or who completed the redetermination process but whose program benefits were terminated by the State.

## Appendix J: Reporting Forms

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

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

Enter the total number of denials sampled for the fiscal 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 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 review 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.

- **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 Detailed Active Case Review Findings forms.

- **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.

These should equal the number of case reported on the Detailed Active Case Review Findings forms completed throughout the fiscal year with findings of E-eligible, EI-eligible with ineligible

## Appendix J: Reporting Forms

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.

Enter the number of denied and terminated cases found correct (code C for cases correctly denied and terminated) through the negative case action reviews throughout the fiscal year as reported on the Detailed Negative Case 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.

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

Enter the number of denied and terminated cases found incorrect through the negative case action reviews throughout the fiscal year as reported on the Detailed Negative Case Review Findings forms (codes ID for improper denials and IT for improper terminations).

- **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.

These should equal the number of case reported on the Detailed Active Case 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, if no evidence exists to support a denial or termination, the case is cited as an improper denial or termination.

- **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 case reviews.

- **Total Dollars Correct Column**

Enter the total dollars paid correctly 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 case reviews.

## **Appendix J: Reporting Forms**

- **Total Dollars in Error Column**

Enter the total dollars paid in error 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 case reviews.

- **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.

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

# Appendix J: Reporting Forms

## Monthly Sample Selection List: MEQC Substitution

<b>A. State</b>			
<b>B. Date</b>			
<b>C. Program</b>			
<b>D. Sample Month</b>			
<b>E. Number of cases in universe that month</b>	<b>Active Cases</b>	<b>Negative Cases</b>	<b>Express Lane Cases</b>
<b>F. Case/Beneficiary Identification</b>			
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			
21)			
22)			
23)			
24)			
25)			
26)			

## **Appendix J: Reporting Forms**

This form is due to CMS on the 15th day of the month after the sample month and must be submitted before eligibility reviews begin.

### **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 Columbia. The Territories are excluded from the PERM program.

### **Line B: Date**

Enter the date that the Monthly Sample Selection form is being submitted to CMS (e.g. February 15, 2010). If this form is being resubmitted, enter the date of resubmission.

### **Line C: Program**

Enter the program for which the Monthly Sample Selection List applies (e.g. Medicaid or CHIP).

### **Line D: Sample Month**

Enter the month for which the sample was drawn from the universe, e.g. January. “Universe” refers to the total number of cases in the sample month. The universe will be unique for each month.

### **Line E: Number of Cases in the Universe for the Sample Month**

Enter the total number of active cases and negative cases in the universe during the sample month. Enter the total number of express lane cases that are excluded from the PERM universe. 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 negative universe is the total number of cases that have either been denied based on a completed application or terminated based on a completed redetermination in the given sample month. The express lane total includes the number of cases excluded from the MEQC universe due to being enrolled in Medicaid or CHIP using Express Lane Eligibility. States substituting MEQC data do not need to stratify cases into the three PERM strata but should identify which strata a case belongs to once it’s reviewed.

### **Line F: Case/Beneficiary Identification (ID)**

“Case” refers to an individual beneficiary or family, unlike the PERM eligibility sampling unit that is the individual beneficiary only. A case, when substituting MEQC data, is a household or family unit. In this row, enter the case identification (ID) or beneficiary ID, whichever is the custom of the State, which correlates with the case reported as sampled on the Monthly Sample Selection List for the sample month.

## **Appendix J: Reporting Forms**

For each case selected for the sample of cases, list the case ID in the column in the Active Case column. For each case selected for the sample of negative cases, list the case ID in the Negative Cases column. The Express Lane Cases column should be left blank as no express lane cases should be sampled.

Add rows if the number of cases in the active case sample for the month being reported exceeds the number of rows provided.

**Oversample:** Include any cases selected as oversample cases in these rows. A State may want to oversample for anticipated drops of MEQC cases that are not applicable PERM cases.

# Appendix J: Reporting Forms

## Detailed Active Case Review Findings: MEQC Substitution

<b>A. State</b>					
<b>B. Date</b>					
<b>C. Program</b>					
<b>D. Sample Month</b>					
<b>E. Case/Beneficiary Identification (ID)</b>	<b>Number of Individuals</b>	<b>Date of Dropped Case</b>	<b>Stratum 1, 2, or 3</b>	<b>Review Finding</b>	<b>Cause of Error</b>  <b>Example: excess income, non resident</b>
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					
13)					
14)					
15)					
16)					
17)					
18)					
19)					
20)					
21)					
22)					
23)					
24)					
25)					
26)					

## Appendix J: Reporting Forms

This form is due within 150 days from the end of the each sample month (i.e. if the sample month is January, the Detailed Active Case Review Findings form is due on June 30, which is 150 days from January 31).

### 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 Columbia. The Territories are excluded from the PERM program.

### Line B: Date

Enter the date that the Detailed Active Case Findings form is being submitted to CMS (e.g. June 15, 2010). If this form is being resubmitted, enter the date of resubmission.

### Line C: Program

Enter the program for which the monthly Detailed Active Case Review Findings form applies (e.g. Medicaid or CHIP).

### Line D: Sample Month

Enter the month for which the sample was drawn from the universe. “Universe” refers to the total number of cases in the sample month. The case universe will be unique for each month.

### Line E: Case/Beneficiary Identification (ID)

“Case” refers to an individual beneficiary or family, unlike the PERM eligibility sampling unit that is the individual beneficiary only. A case, when substituting MEQC data, is a household or family unit. In this row, enter the case identification (ID) or beneficiary ID, whichever is the custom of the State, which correlates with the case reported as sampled on the monthly sample selection list for the sample month.

Add rows if the number of cases in the active case sample for the month being reported exceeds the number of rows provided.

- **Number of individuals**

Enter the number of individuals included in the sampled case.

- **Date of Dropped Case**

A State can only drop and replace a case from the PERM eligibility sample for the following reasons:

## Appendix J: Reporting Forms

1. A case which should have been excluded from the sampling universe was inadvertently included in the universe and sampled (this applies to cases subject to an MEQC review but not a PERM review), or
2. A case is found to be under active beneficiary fraud investigation.

“Active beneficiary fraud investigation” is defined as a beneficiary’s name has been referred to the State Fraud and Abuse Control or similar investigation unit and the unit is currently actively pursuing an investigation to determine whether the beneficiary committed fraud.

States should exclude these cases from the universe. However, if a State cannot exclude these cases from the universe, the State can drop these cases if they appear in the sample.

Do not enter a review finding for dropped cases.

Other reasons for cases to be dropped from the MEQC review are not applicable for the PERM reviews, e.g. client cannot be located. If a potentially dropped case falls under the classification of an “undetermined” case, it must be reported as such.

- **Stratum**

Enter the number of the eligibility stratum for the case (e.g. Stratum 1). The strata are as follows:

- o **Stratum 1—Applications:** A case constitutes an “application” for the sample month if the State took an action to grant eligibility in that month based on a completed application.
- o **Stratum 2—Redeterminations:** A case constitutes a “redetermination” for the sample month if the State took an action to continue eligibility in the sample month based on a completed redetermination.
- o **Stratum 3—All Other Cases:** All other cases (properly included in the universe but do not meet the Strata 1 or 2 criteria) that are on the program in the sample month are placed in Stratum 3.

- **Review Finding**

Enter the letter code for the review finding (e.g. MCE1) for each case. The eight review findings are defined as follows:

- **E-Eligible:** A case meets the State’s categorical and financial criteria for receipt of benefits under the program.
- **EI- Eligible with ineligible services:** A case meets the State’s categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs but was not eligible to

## Appendix J: Reporting Forms

receive particular services. An example of “eligible with ineligible services” would be a case where a person eligible under the medically needy group received services not provided to the medically needy group. Another example would be a person enrolled as a Qualified Medicare Beneficiary (QMB), but upon further review is determined to be eligible as a Specified Low-Income Medicare Beneficiary (SLMB).

- **NE-Not eligible:** A case is receiving benefits under the program but does not meet the State’s categorical and financial criteria for the month eligibility is being verified.
- **U-Undetermined:** A case subject to a Medicaid or CHIP eligibility review decision under PERM for which a definitive eligibility review decision could not be made.
- **L/O-Liability overstated:** The beneficiary paid too much toward his liability amount or cost of institutional care and the State paid too little; or a beneficiary’s premium payment was miscalculated and based on this miscalculation the State paid too little towards a managed care organization (MCO) capitation payment on his/her behalf.
- **L/U-Liability understated:** The beneficiary paid too little toward his liability amount or cost of institutional care and the State paid too much; or a beneficiary’s premium payment was miscalculated and based on this miscalculation the State paid too much towards an MCO capitation payment on his/her behalf.
- **MCE1-Managed care error, ineligible for managed care:** Upon verification of residency and program eligibility, the case is enrolled in managed care but is not eligible for managed care.
- **MCE2-Managed care error, eligible for managed care but improperly enrolled:** The case 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.

**Note:** Some review findings will not be definitive until the payment reviews are conducted.

Leave this column blank if a case is dropped or oversample cases are not used.

- **Cause of Error:** Enter the cause of the error for cases not eligible for the program. Explanations for this column are not standardized but should reflect the State’s finding that caused the case to be in error. Do not use State-specific codes or abbreviations.

# Appendix J: Reporting Forms

## Detailed Payment Review Findings: MEQC Substitution

<b>A. State</b>							
<b>B. Date</b>							
<b>C. Program</b>							
<b>D. Sample Month</b>							
<b>E. Case/Beneficiary Identification (ID)</b>	<b>Number of Individuals</b>	<b>Date of Dropped Case</b>	<b>Stratum 1,2 or 3</b>	<b>Review Finding</b>	<b>Payment Amount Correct</b>	<b>Payment Amount in Error</b>	<b>Payment Amount Undetermined</b>
1)							
2)							
3)							
4)							
5)							
6)							
7)							
8)							
9)							
10)							
11)							
12)							
13)							
14)							
15)							
16)							
17)							
18)							
19)							
20)							
21)							
22)							
23)							
24)							

## Appendix J: Reporting Forms

This form is due 210 days from the end of the sample month (i.e. the payment review for the sample month of January is due on August 31, which is 210 days from January 31).

### 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 Columbia. The Territories are excluded from the PERM program.

### Line B: Date

Enter the date that the Detailed Payment Review Findings form is being submitted to CMS (e.g. June 15, 2010). If this form is being resubmitted, enter the date of resubmission.

### Line C: Program

Enter the program for which the Detailed Payment Review Findings form applies (e.g. Medicaid or CHIP).

### Line D: Sample Month

Enter the month for which the sample was drawn from the universe. “Universe” refers to the total number of cases in the sample month. The case universe will be unique for each month.

### Line E: Case/Beneficiary Identification (ID)

“Case” refers to an individual beneficiary or family, unlike the PERM eligibility sampling unit that is the individual beneficiary only. A case, when substituting MEQC data, is a household or family unit. In this row, enter the case identification (ID) or beneficiary ID, whichever is the custom of the State, which correlates with the case reported as sampled on the Monthly Sample Selection List for the sample month.

Add rows if the number of cases in the active case sample for the month being reported exceeds the number of rows provided.

**Note:** Include all sample cases in this table, not just those with payment errors.

- **Number of Individuals**

Enter the number of individuals included in the sampled case.

- **Date of Dropped Case**

A State can only drop and replace a case from the PERM eligibility sample for the following reasons:

## Appendix J: Reporting Forms

1. A case should have been excluded from the sampling universe but was inadvertently included in the universe and sampled (this applies to cases subject to an MEQC review but not a PERM review), or
2. A case is found to be under active beneficiary fraud investigation.

“Active beneficiary fraud investigation” is defined as a beneficiary’s name has been referred to the State Fraud and Abuse Control or similar investigation unit and the unit is currently and actively pursuing an investigation to determine whether the beneficiary committed fraud.

States should exclude these cases from the universe. However, if a State cannot exclude these cases from the universe, the State can drop these cases if they appear in the sample.

Do not enter a review finding for dropped cases.

Other reasons for cases to be dropped from the MEQC review are not applicable for the PERM reviews, e.g. client cannot be located. If a potentially dropped case falls under the classification of an “undetermined” case, it must be reported as such.

- **Stratum**

Enter the number of the eligibility stratum for the case (e.g. Stratum 1). The strata are as follows:

- o **Stratum 1—Applications:** A case constitutes an “application” for the sample month if the State took an action to grant eligibility in that month based on a completed application.
- o **Stratum 2—Redeterminations:** A case constitutes a “redetermination” for the sample month if the State took an action to continue eligibility in the sample month based on a completed redetermination.
- o **Stratum 3—All Other Cases:** All other cases (properly included in the universe but do not meet the Strata 1 or 2 criteria) that are on the program in the sample month are placed in Stratum 3.

- **Review Finding**

Enter the letter code for the review finding (e.g. MCE1) for each case. The eight review findings are defined as follows:

- **E-Eligible:** A case meets the State’s categorical and financial criteria for receipt of benefits under the program.
- **EI- Eligible with ineligible services:** A case meets the State’s categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs but was not eligible to

## Appendix J: Reporting Forms

receive particular services. An example of “eligible with ineligible services” would be a case where a person eligible under the medically needy group received services not provided to the medically needy group. Another example would be a person enrolled as a Qualified Medicare Beneficiary (QMB), but upon further review is determined to be eligible as a Specified Low-Income Medicare Beneficiary (SLMB).

- **NE-Not eligible:** A case is receiving benefits under the program but does not meet the State’s categorical and financial criteria for the month eligibility is being verified.
- **U-Undetermined:** A case subject to a Medicaid or CHIP eligibility review under PERM for which a definitive eligibility review decision could not be made.
- **L/O-Liability overstated:** The beneficiary paid too much toward his liability amount or cost of institutional care and the State paid too little; or a beneficiary’s premium payment was miscalculated and based on this miscalculation the State paid too little towards a managed care organization (MCO) capitation payment on his/her behalf.
- **L/U-Liability understated:** The beneficiary paid too little toward his liability amount or cost of institutional care and the State paid too much; or a beneficiary’s premium payment was miscalculated and based on this miscalculation the State paid too much towards an MCO capitation payment on his/her behalf.
- **MCE1-Managed care error, ineligible for managed care:** Upon verification of residency and program eligibility, the case is enrolled in managed care but is not eligible for managed care.
- **MCE2-Managed care error, eligible for managed care but improperly enrolled:** The case 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.

Leave this column blank if a case is dropped or oversample cases are not used.

- **Payment Amount Correct**—A correct payment amount is a payment to a provider, insurer or managed care organization based on the beneficiary’s eligibility for the program and for the services received under the coverage group under which the beneficiary is eligible as defined in the State’s plan.
  - o For fee for service cases, enter the total amount of dollars paid for the beneficiary based on claims for services rendered at any time during the first 30 days of eligibility, in the sample month or in the spenddown period (if appropriate) which are paid by the end of the fourth month after the review month (or sample month for cases in Stratum 3).
  - o For managed care cases, enter the capitated amount paid for the case. All managed care payments made for coverage in the review month (for Strata 1 and 2 cases) and the sample

## Appendix J: Reporting Forms

month (for Stratum 3 cases) are included regardless of the actual payment date so long as the payment dates fall within the review month (for cases in Strata 1 and 2) or sample month and are paid by the end of the fourth month after the review month or sample month. In some States, managed care payments are made to managed care organizations in the month before or the month following the month of coverage. Prospective payments for the sample month will be counted.

- o For States that offer fee for service “carve out” services alongside managed care coverage, the capitation payment with the additional fee for service payments should be included in the payment review.
- o For States that accept premium payments from beneficiaries for coverage, the premium payment from the beneficiary should not be included in the payment review, but instead considered to determine whether the State portion of a capitation payment paid to the appropriate MCO was in the correct amount.

Enter the portion of the payments, in whole or in part as appropriate, that were correct for each sampled case. Do not enter payment amounts for cases that are dropped.

Place a zero in this column if there is no correct payment amount.

- **Payment Amount in Error**—Enter the amount of payment that is in error based on the beneficiaries’:
  - o Ineligibility for services received,
  - o Ineligibility for the program,
  - o Liability overstated or understated,
  - o Ineligibility for managed care, or
  - o Eligibility for managed care but enrollment in the wrong managed care plan.

Enter the portion of the payment, 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.

- **Payment Amount Undetermined**—Enter the amount of payment that is 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.

## **Appendix J: Reporting Forms**

PERM does not use thresholds to determine payment amounts in error. States must use actual payment amounts when reporting improper payments using MEQC data.

Leave payment columns blank if a case is dropped or oversample cases are not used.

# Appendix J: Reporting Forms

## Summary Findings: MEQC Substitution

<b>A. State</b>										
<b>B. Date</b>										
<b>C. Program</b>										
	<b>Number of Cases in Universe</b>	<b>Number of Cases Sampled</b>	<b>Number of Individuals Sampled</b>	<b>Number of Cases Correct</b>	<b>Number of Cases Incorrect</b>	<b>Number of Cases Undetermined</b>	<b>Total Dollars Paid</b>	<b>Total Dollars Correct</b>	<b>Total Dollars in Error</b>	<b>Total Dollars Undetermined</b>
<b>D. Active</b>										
<b>Stratum 1</b>										
<b>Stratum 2</b>										
<b>Stratum 3</b>										
<b>E. Negative</b>										
<b>Denials</b>										
<b>Terminations</b>										
<b>F. Totals</b>										

<b>Number of Cases Dropped from Sample</b>	
--	--

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

## Appendix J: Reporting Forms

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 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 Columbia. 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 equal to the sum of Strata 1, 2 and 3. An active case is a case containing information on beneficiaries who were enrolled in the program on the sample month.

**Stratum 1—Applications:** A case constitutes an “application” for the sample month if the State took an action to grant eligibility in that month based on a completed application.

Enter the total number of active cases in Stratum 1, Applications, sampled for the fiscal year.

**Stratum 2—Redeterminations:** A case constitutes a “redetermination” for the sample month if the State took an action to continue eligibility in the sample month based on a completed redetermination.

Enter the total number of active cases in Stratum 2, Redeterminations, sampled for the fiscal year.

**Stratum 3—All Other Cases:** All other cases (properly included in the universe but do not meet the Strata 1 or 2 criteria) that are on the program in the sample month are placed in Stratum 3.

Enter the total number of active cases in Stratum 3, All Other Cases, sampled for the fiscal year.

### Line E: Negative

A negative case is a case where a beneficiary completed an application for benefits and the State denied the application or who completed the redetermination process but whose program benefits were terminated by the State.

## Appendix J: Reporting Forms

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

**Denials**—Denials occur when the State rejected a completed application for not meeting categorical and financial eligibility requirements.

Enter the total number of denials sample for the fiscal 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 of the active cases and total number of cases sampled as denied and terminated for negative cases. In column three, enter the total number of individuals sampled in each stratum of the active cases and total number of individuals sampled as denied and terminated for negative cases.

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 review 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.

- **Number of Individuals Sampled Column**

Enter the number of individuals within the sampled cases in each of the categories in the rows.

- **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.

## Appendix J: Reporting Forms

These should equal the number of case reported on the Detailed Active Case Review Findings forms completed throughout the fiscal year with findings of 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.

Enter the number of denied and terminated cases found correct (code C for cases correctly denied and terminated) through the negative case action reviews throughout the fiscal year as reported on the Detailed Negative Case 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.

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

Enter the number of denied and terminated cases found incorrect through the negative case action reviews throughout the fiscal year as reported on the Detailed Negative Case Review Findings forms (codes ID for improper denials and IT for improper terminations).

- **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.

These should equal the number of case reported on the Detailed Active Case 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, if no evidence exists to support a denial or termination, the case is cited as an improper denial or termination.

- **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 case reviews.

- **Total Dollars Correct Column**

Enter the total dollars paid correctly that corresponds with each of the categories described in the rows.

## Appendix J: Reporting Forms

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

- **Total Dollars in Error Column**

Enter the total dollars paid in error 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 case reviews.

- **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.

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

- **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 Detailed Active Case Review Findings forms.