Payment Error Rate Measurement (PERM)
Verifying Eligibility
for
Medicaid and SCHIP Benefits

Contents

Appendices

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 State Children's Health Insurance Program (SCHIP) 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, CMS developed the Payment Error Rate Measurement (PERM) program. Under PERM, reviews will be conducted in three areas: (1) fee-for-service (FFS), (2) managed care, and (3) program eligibility for both the Medicaid and SCHIP programs. The results of these reviews will be used to produce national program error rates, as required under the 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 will be responsible for measuring the third area, program eligibility, for both programs. Because States administer Medicaid and SCHIP 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 SCHIP 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) 2007-2009 (which will rotate thereafter) are as follows:

States Selected for Medicaid and SCHIP Improper Payment Measurements

FY 2007	North Carolina, Georgia, California, Massachusetts, New Jersey, Tennessee, West Virginia, Kentucky, Maryland, Alabama, South Carolina, Colorado, Utah, Vermont, Nebraska, New Hampshire, Rhode Island
FY 2008	New York, Florida, Texas, Louisiana, Indiana, Mississippi, Iowa, Maine, Oregon, Arizona, Washington, District of Columbia, Alaska, Hawaii, Montana, South Dakota, Nevada
FY 2009	Pennsylvania, Ohio, Illinois, Michigan, Missouri, Minnesota, Arkansas, New Mexico, Connecticut, Virginia, Wisconsin, Oklahoma, North Dakota, Wyoming, Kansas, Idaho, Delaware

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 SCHIP. States will conduct the eligibility reviews of Medicaid and SCHIP cases and calculate State-specific eligibility error rates for reporting to CMS. CMS' statistical contractor will combine the State-reported eligibility error rates to develop national eligibility error rates for Medicaid and SCHIP.

States will not be provided the option to use the PERM eligibility reviews to satisfy Medicaid Eligibility Quality Control (MEQC) program requirements. The PERM program is intended to

fulfill the requirements of the IPIA and is not intended to supplant, enhance, or change other program integrity activities in which the States are currently engaged. We are providing the option for States to contract out the eligibility measurement to entities independent of States' Medicaid and/or SCHIP eligibility determination and enrollment activities. We are considering methods to minimize duplication of efforts regarding the eligibility reviews. As we work with all States and gain experience with the Medicaid and SCHIP 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.

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. 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 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. States will calculate a case and a payment error rate for active cases and a case error rate for negative cases. A glossary is provided that defines terms used throughout these instructions. Finally, CMS designated the first quarter of FY 2007 as an implementation timeframe for States to prepare for the FY 2007 eligibility reviews, which will be condensed over a nine month timeframe (refer to the eligibility measurement timeline in Appendix A). For FY 2008 and beyond, the reviews will occur on an annual basis and State sampling plans are due 60 days prior to the start of the fiscal year (i.e., by August 1). Refer to Appendix A for a complete PERM eligibility sampling and review timeline.

Eligibility Overview

The eligibility component of PERM will result in the calculation of an error rate to determine what percentage of Medicaid and SCHIP total payments made for services to beneficiaries in the sample were improperly paid. 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 each State will measure the State error rate by creating a universe of beneficiaries, stratifying beneficiaries based on case status, performing a random sample within each strata to review the sampled cases.

States will draw a sample each month of the federal fiscal year in which they are participating in PERM (see Section 3). The sample will be broken into two main groups: active cases and negative cases. Active cases are those in which an individual is on the Medicaid or SCHIP 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: stratum one (applications), stratum two (redeterminations), and stratum three (all other cases). Therefore, States will draw a sample each month from the following four sampling universes:

- Stratum one (applications),
- Stratum two (redeterminations),
- Stratum three (all other cases),
- Negative – denied and terminated cases.

Once the sample has been drawn, States will review each case to verify eligibility according to the procedures outlined below in Section 4. For sampled active cases (strata one, two and three), States will identify payments for services received in the first 30 days of eligibility or the sample month, depending upon whether the State grants full-month or date-specific coverage. States should only collect payments in that timeframe and in the four months following that month. In addition, all adjustments that occur within 60 days of the payment date should be included (see Section 5). Each State is also responsible for reporting the monthly sample, the active and negative review findings, the payment collection information, and the payment and case error rates to CMS (see Section 6).

The sample and subsequent review and payment collection will allow each State to calculate three error rates for eligibility:

1) the active case error rate - the percentage of the number of individuals incorrectly granted eligibility (calculated from the results of the active case review findings);
2) 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);
3) the negative case error rate - the percentage of the number of individuals whose eligibility was incorrectly denied or terminated (calculated from the results of the negative case review findings).

Sampling

This section provides statistical and operational guidance for sampling cases which will be used to estimate eligibility error rates for Medicaid and SCHIP. 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 SCHIP universe are those where all services *are paid with title XXI funds including Medicaid-expansion cases that are funded under SCHIP*.**

Also note that, for PERM purposes, a "case" is defined as an individual beneficiary, not a household or family unit. If your State's data systems are at the family or assistance unit level, rather than at the beneficiary level, there are ways to minimize the potential complexities of sampling at the beneficiary level. Please contact the Statistical Contractor for more information.

States participating in FY 2007 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 CMS' statistical contractor for approval by November 15, 2006. The statistical contractor will work with any State to ensure the sampling plan meets the requirements in these instructions and is approved by January 15, 2007.

States participating in FY 2008 and beyond 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. For FY 2007, the full sample will be drawn over a nine month period, from January

through September 2007. For FY 2008 and beyond, the full sample will be drawn over a twelve month period, from October through September.

Although States will draw separate samples for Medicaid and SCHIP, the procedures for sampling are the same for both programs. These instructions will distinguish between Medicaid and SCHIP 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. States will calculate two error rates for active cases. The first is a "dollar weighted" or "dollar" error rate using the dollar value of payments made for services. In addition, a simple case error rate (eligible or ineligible) 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 no services were 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 one (applications), stratum two (redeterminations), and stratum three (all other cases).

3.1.1 Identifying Active Case Universe

An active case is a case that contains information regarding an individual beneficiary enrolled in the Medicaid program or in the SCHIP program in the sample month. Note that the distinction in enrollment, between the Medicaid and SCHIP universes, is determined by the program funding the services, that is, a Medicaid-expansion case is included in the SCHIP 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;
- For Medicaid only, Supplemental Security Income cash cases in States with an agreement with the Social Security Administration under section 1634 of the Social Security Act, and
- For Medicaid only, adoption assistance and foster care cases under title IV-E.

3.1.2 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 one (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 one. Note: States should count an individual reapplying for Medicaid or SCHIP after a break in eligibility as a new application and place the case in stratum one unless the case has been pended for non-payment of premium. If there is any other situation where a State reinstates an individual after a break in coverage, the State must get CMS approval to exclude these cases from stratum one. This information should be in the State's sampling plan upon submission.
- Stratum two (redeterminations): A case constitutes a "complete redetermination" for the sample month if the State took an action to continue eligibility in the sample month based on a completed redetermination. These cases are placed in stratum two. For PERM purposes a redetermination occurs any time the State took an action to redetermine eligibility, not just during the State-defined three, six, or twelve-month redetermination period.
- Stratum three (all other cases): All other cases (properly included in the universe but do not meet the strata one or two criteria) that are on the program in the sample month are placed in stratum three.

PERM defines a "complete application" and a "complete redetermination" as an application or a redetermination where the beneficiary met all Medicaid and/or SCHIP 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.

3.1.3 Sampling Stratified Active Cases

Sampling in stratum one and stratum two should be based on either the decision month or the effective month.

- The decision month is the month when a State makes a decision to grant or continue eligibility to a beneficiary after an application review or redetermination is complete.
- The effective month is the month when the beneficiary becomes eligible to receive Medicaid or SCHIP services.

Cases in stratum one (applications) and stratum two (redeterminations) should be sampled in either the decision month or the effective month, ***whichever is later.*** States should not include a case in stratum one new applications or stratum two redeterminations in any month prior to when the decision to grant or continue eligibility was made.

Cases in stratum three all other cases should be sampled for each month in which the beneficiary is receiving Medicaid or SCHIP 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 one (applications) 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 in February. Therefore this case should be placed into stratum two (redeterminations) 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 SCHIP. 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 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:

	January	**February**	**March**	**April**	**May**
Beneficiary A Example of date-specific eligibility	first month of 3-month retroactive period	second month of 3 –month retroactive period	third month of 3-month retroactive period	Person applies for Medicaid. State decides person is eligible and puts on rolls effective April 21st .	On-going coverage
	Not in sampling universe; no payments collected	Not in sampling universe; no payments collected	Not in sampling universe; no payments collected	In stratum one (applications) sampling universe; payments collected if sampled	In stratum three (all other cases); payments collected if sampled
Beneficiary B Example of full month eligibility	first month of 3-month retroactive period	second month of 3 –month retroactive period	third month of 3-month retroactive period	Person applies for Medicaid. State decides person is eligible and puts on rolls effective April 1st .	On-going coverage
	Not in sampling universe; no payments collected	Not in sampling universe; no payments collected	Not in sampling universe; no payments collected	In stratum one (applications) sampling universe; payments collected if sampled	In stratum three (all other cases); payments collected if sampled

3.1.4 Stratifying Active Cases – Additional sampling situations

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 one and stratum two cases that have an effective date in September. Cases approved or redetermined for coverage in September for eligibility beginning in October should not be included in the September sampling universe. Example: A State decides on September 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 SCHIP, 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 and the SCHIP negative universe in the sample month. A joint application that is approved for SCHIP would be placed in the SCHIP active universe and the Medicaid negative universe in the sample month.

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 three (all other cases) until the State redetermines eligibility.
- The State should place SSI conversion cases in stratum two (redeterminations) 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

In FY 2007, the sample will be drawn over the last nine months of the fiscal year, as shown in Exhibit 2.1. In FY 2008 and subsequent years, the sample will be drawn over the full 12 months of the fiscal year, as shown in Exhibit 3.4.

The initial sample size is calculated under the assumption that the error rate is 5 percent. This means that the desired precision requirements will be achieved with a high probability if the actual error rate is 5 percent or less. For this reason, an annual sample of 504 cases should meet State-level precision requirements with a high probability. In subsequent years, 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.

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

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

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:

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

and

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

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

The allocation of the sample as expressed in the second equation will not be used. This situation would be ideal, but due to the majority of payments occurring in the "all other cases" category, stratum three might be underrepresented in the sample. The loss in precision, however, should be small.

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

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

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. 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

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

3.1.6 Method for Drawing the Monthly Sample

For FY 2007 States will draw the total sample over the course of nine months, with each monthly sample drawn from a universe that is unique for the month. In FY 2008 and subsequent years States will draw the sample over the course of the entire twelve-month fiscal year. Initially, for FY 2007, 2008 and 2009, the total annual sample size for each program will be 504 cases for the active case payment error rate, unless the State has an approved sampling plan with a reduced sample size based on the finite population correction. 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 one (applications), stratum two (redeterminations) and stratum three (all other cases) and sample cases within each strata. To determine whether stratum one or stratum two applies, the State should evaluate the decision date or the effective date of the action, ***whichever is later***. The stratum three universe should consist of cases where the beneficiary is receiving Medicaid or SCHIP 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 one in a month and stratum three the next month, and in stratum two or stratum three 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.

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 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 1000, and a sample of 22 is needed, assign each case an integer from 1 to 1000. Then generate 22 random integers between 1 and 1,000, without replacement. Cases that were assigned one of the randomly generated integers would be included in the sample.

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 1000, and a sample size of 20 is needed, the skip interval would be 50. A random integer would be generated between 1 and 50 (inclusive of the end points). If this random number was 7, then, sample case number 7, case number 57, case number 107, etc. until the required 20 cases were drawn. States may include oversample cases with the required cases when using the "skip" factor method. However, as discussed later in this section, States may want to draw an oversample in case any problems are discovered in the sampled (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).

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 three (all other cases) 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 payment across strata, an equal number of cases will be drawn from each of the three strata each month in future years over a 12 month period.

For FY 2007, the sample will be drawn from the last nine months of the federal fiscal year, as shown in Exhibit 3.3, but the number sampled in each month will be increased proportionately to obtain the same overall sample size in each of the three strata that would be obtained with a full 12-month sample. Unless the State has an approved alternative due to the finite population correction[1], 18 active cases will be sampled each month in each stratum for the second quarter of FY 2007 (January, February, and March), and 19 active cases will be sampled each month in each stratum in the third and fourth quarters of FY 2007 (April through September).

For FY 2008 and FY 2009, the sample will be drawn from the full twelve months of the federal fiscal year, as shown in Exhibit 3.4 and will equal a total of 504 cases. Unless the State has an

[1] 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.

approved alternative due to the finite population correction[2], 14 cases will be sampled each month in each stratum for the twelve month federal fiscal year. Note: For FY 2010 and beyond, active case sample sizes will depend on the State's most recent error rate.

Exhibit 3.3: Sample Size by Stratum in 2007

Stratum	Month											
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1. Applications				18	18	18	19	19	19	19	19	19
2. Redeterminations				18	18	18	19	19	19	19	19	19
3. All other cases				18	18	18	19	19	19	19	19	19

Exhibit 3.4: Sample Size by Stratum in FY 2008 and FY 2009

Stratum	Month											
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1. Applications	14	14	14	14	14	14	14	14	14	14	14	14
2. Redeterminations	14	14	14	14	14	14	14	14	14	14	14	14
3. All other cases	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 Tracking Tool (PETT) Website, no later than the 15th day of the month following the sample month (see Section 7).

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

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

If errors are identified in the Medicaid and SCHIP eligibility universes (e.g., State-only funded cases are found in the universe, etc.) causing changes to the sample once the monthly sample selection list has been submitted, States should contact the Statistical Contractor immediately upon the identification with specific information regarding why the sample is being changed and resubmit a revised sample list to the PETT website. When developing the sampling plan, States should consider the potential need for randomly selected replacement cases and may want to oversample.

[2] 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.

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 (all other cases). 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 3 (all other cases) but upon review finds that the case was a State-only funded case with no Federal match dollars. The State should drop this case and replace the case with one that has been oversampled.

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, this could be an indication that the State's quality control of the data needs improving.

3.2 Negative Case Sample

Negative cases are cases where the State denied an application or terminated eligibility. The sampling plan for negative cases should be included within the sampling 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 and all cases where the State terminated eligibility in the sample month should be included in the negative universe for that month. 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. No other exclusion criteria apply. There are no provisions for States to drop cases from review and replace them with other cases.

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

A minimum sample size of 204 is required. However, if the State's universe for the previous fiscal year is less than 10,000, 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 2.1.3. 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 previous equation in section **3.1.5. Sample Size**, except that K is zero:

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

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 that 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

States will draw the total sample of 204 cases over the course of nine months in FY 2007. The FY 2007 sample size should consist of at least 22 cases for three months and 23 cases for the last six months, as shown in Exhibit 3.5. In FY 2008 and subsequent years, the sample will be drawn from this universe of negative cases over the entire twelve months of the Federal fiscal year. In FY 2008 and FY 2009, the sample size should consist of 17 cases for each month of the Federal fiscal year, as shown in Exhibit 3.6. States may not change the required sample size unless the statistical contractor approves a reduced sample size due to the finite population correction.

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 Section 3.1.6 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 PETT website by the 15th day of the month following the sample month and prior to commencing the reviews as specified in Section 7.

Exhibit 3.5: Sample Size by Stratum in FY 2007

Stratum	Month											
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Negative Determinations				22	22	22	23	23	23	23	23	23

Exhibit 3.6: Sample Size by Stratum in FY 2008 and FY 2009

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

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 SCHIP 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. This 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 determination and enrollment or that the contracting entity is independent of the State's eligibility and enrollment activities.

States should complete 90 percent of case reviews within 105 days of the end of the sample month, 95 percent within 125 days of the end of the sample month, and complete and report detailed findings on 100 percent of the cases within 150 days of the end of the sample month (see Section 7). For a timeline of the complete eligibility measurement process, please see Appendix A.

4.1 Review Month vs. Sample 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. The sample month is the month in which the case is sampled.

For stratum one (applications) and stratum two (redeterminations) cases, the review month is the month in which a decision was made to grant eligibility or extend eligibility coverage. The sample month for stratum one (applications) and stratum two (redeterminations) cases is either the month the decision was made (the review month) or the month in which the decision becomes effective, whichever is later.[3]

[3] For FY 2007, States had the option to use the decision date or effective date for PERM sampling based on changes to PERM policy after FY 2007 States had submitted eligibility sampling plans.

For cases in stratum one (applications) and stratum two (redeterminations), the review month and the sample month are the same for States that grant eligibility in the month the decision is made. Example: A State makes a decision to grant eligibility on January 15th and provided full month coverage for back to January 1st. The review month and the sample month would be January.

For cases in stratum one (applications) and stratum two (redeterminations), the review month and the sample month are not the same for States that grant eligibility prospectively. Example: A State makes a decision to grant eligibility on January 15th for eligibility coverage beginning on February 1st. The sample month would be February while the review month would be January.

For cases in stratum three (all other cases), 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. The last action taken in the case was in the previous January. Eligibility would be verified as 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 2007. The State's last action (the review month) occurred in May 2006. Eligibility for this case is verified as of the review month of May 2006.
>
> Example 2: A stratum 3 case is sampled in January 2007. The State's last action (the review month) occurred in December 2005. Since the last action occurred more than 12 months prior to the sample month of January 2007, eligibility is verified as of January 2007.

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 SCHIP.) 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 one and two because these cases are reviewed as of the State's most recent action. 2) For cases in stratum three, eligibility also is 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 case review is to verify eligibility following State policies in effect at the time of the review (so long as the policies 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 the documentation specified, eligibility can be verified through other reasonable evidence.

4.2.1 Acceptable Documentation

The agency must examine the evidence in the case file and, if needed, independently verify elements of eligibility where evidence is: (1) missing; or (2) outdated (i.e., older than 12 months from the sample month) and likely to change. 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

Categorical Criteria Unlikely to Change	Financial Criteria Unlikely to Change
Citizenship (in month eligibility is being verified)	Cash – Resource
Social Security Number	House, other property – Resource
Death	Vehicle – Resource
Birth date	Life insurance – Resource
Pregnancy (in month eligibility is being verified)	Personal effects (e.g., boat, camper) – Resource
Categorical Criteria Likely to Change	**Financial Criteria Likely to Change**
Residency	Bank account – Resource
Household Composition	Earned Income – e.g., wages and salary
	Unearned income – e.g., retirement and government benefits

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 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
- Self-declaration that complies with section 4.2.2 below.
- Also refer to section 7269 of the State Medicaid Manual (SMM) for listings of acceptable primary and secondary documentation for each element of eligibility.

4.2.2 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/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, which requires documentation of citizenship for Medicaid effective July 1, 2006. State Medicaid policy that allows for self-declaration of citizenship will need to be revised to comply with this new requirement. These citizenship verification requirements do not apply to separate SCHIP programs and States may adopt their own requirements in this regard for SCHIP. States should refer to Federal Medicaid and SCHIP eligibility rules at 42 CFR Part 435 and Part 457 for other Federal verification requirements.

Self-declaration is considered acceptable verification for meeting categorical and financial requirements listed as unlikely to change in Exhibit 3.1 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 more than 12 months beyond 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) through documentation as of the month eligibility is being verified for Medicaid, or (2) with documentation or a new self-declaration statement from the beneficiary for the month eligibility is being verified for SCHIP that meets the State's official written policy. The new self-declaration is acceptable 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 and the agency cannot verify eligibility through other means, cite the case as "undetermined."

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

For Medicaid, States must always verify through documentation:

- Citizenship

- Residency
- Household composition
- Bank Accounts
- Earned and unearned income,
- Actual enrollment in the plan for managed care beneficiaries.

For SCHIP, the agency can verify these elements through documentation or through a new self declaration that meets the self-declaration criteria.

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:

- 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 SCHIP screen-and-enroll requirements);
- Failure to apply for other program benefits for which the individual is eligible (e.g., food stamps) 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.

4.4 Process for Conducting Medicaid and SCHIP Active Case Reviews

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

Also, note that to facilitate and expedite the eligibility process in certain situations, under Federal law States may provide presumptive eligibility, 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 Act).

Presumptive eligibility for Medicaid allows States to enroll pregnant women, for a limited time, before they are required to file a full application. These cases are reviewed according to State policies 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 SCHIP program also provides for presumptive eligibility. Verify SCHIP eligibility according to State policies governing the coverage group under which the person is receiving benefits.

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 SCHIP 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 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 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 10th of the month) or until the end of the next month (if notification is received after the 10th of the month) and requires a "prompt redetermination of eligibility." In 1634 States, Medicaid eligibility depends on the receipt of SSI cash. When SSI cash is lost then Medicaid eligibility no longer exists on this basis and the State must promptly redetermine eligibility to see if the person is eligible under another category. Cases falling in the "pending time", in compliance with Federal regulations (when SSI is lost and before the State does the redetermination) will be put in stratum 3. 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 ineligible.

4.5 Process for Verifying 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).

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, inconsistent with other facts, unacceptable under self-declaration guidelines, or required under these instructions.

Step 3. For SCHIP cases, verify whether the beneficiary was ineligible for Medicaid.

a. If the beneficiary was ineligible for Medicaid, continue to Step 4.
b. If the beneficiary was eligible for Medicaid, cite the case "ineligible" for SCHIP 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. For SCHIP, verify the case is eligible based on acceptable documentation by meeting all SCHIP eligibility criteria.

a. If the beneficiary is eligible, cite the case "eligible" and proceed to Step 4c.
b. If the beneficiary is ineligible for the coverage category, determine eligibility for other related coverage categories.
   i. If after examining all related categories, the beneficiary is still ineligible for the program, cite the case "ineligible" and proceed to Step 5.
   ii. If the beneficiary is eligible for the program but under another coverage category, cite the case eligible and proceed to Step 4c.
c. Determine whether the beneficiary was enrolled in managed care.
   i. If the beneficiary was not enrolled in managed care, proceed to Step 5.
   ii. 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.
   iii. If the beneficiary was ineligible for managed care, cite the case MCE1 (managed care error, ineligible for managed care) or was eligible for managed care but was enrolled in the wrong plan, cite the case MCE 2 (managed care error, eligible for managed care but improperly enrolled) and proceed to Step 5.
   iv. If the beneficiary is eligible and enrolled correctly, proceed to Step 5.
d. 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, relatives, 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, cite the case "undetermined" and proceed to Step 5. Note that these cases should not be cited "eligible" or "ineligible" or dropped from review. The agency must record all actions, including dates and times, taken to contact the beneficiary before citing the case "undetermined."

Step 5. Record the Medicaid or SCHIP case review finding "eligible," "ineligible," or "undetermined." (Managed care cases that are eligible for Medicaid or SCHIP 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 ineligible or with managed care errors 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 approved by CMS 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 should only consider those technical errors defined by CMS as outlined in Section 4.3.

NOTE: States can cite a case as "undetermined" if, after due diligence, an eligibility determination could not be made. States will identify with the particular beneficiary the 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.

4.6 Process for Conducting Medicaid and SCHIP Negative Case Reviews

The negative case review process, which is identical for both Medicaid and SCHIP, 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 SCHIP Negative Case Review Process, please see Appendix G.

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 SCHIP can be for any circumstance, 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 4.1.1. Acceptable Documentation in these instructions as well as section 7269 of the State Medicaid Manual.

a. If the reason for the beneficiary's denial or termination of benefits was correct, cite the case "correct."
b. 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.
   i. If the evidence indicates another reason for denial or termination, cite the case "correct."
   ii. If no evidence exists to support the denial or termination, cite the case "improper denial" or "improper 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 cases 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.

Payment Reviews of Active Medicaid and SCHIP 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 collection claims. For cases in strata one and two, the agency will identify payments for services received in the review month or the first 30 days of eligibility, depending upon whether the State grants full-month or date-specific eligibility. Payments for cases in stratum three are identified as of the sample month. Only include payments 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.

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 SCHIP, can be made effective prospectively. The date of coverage dictates how the agency will associate claims.

- In States with full month coverage, the agency would associate all payments for services received in the review month, which is also the sample month (strata one and two cases).
  Example: An applicant applies for Medicaid and is eligible on January 15th, but the State makes eligibility is effective January 1. The State would collect payments for services received in January and paid in January, February, March, April and May plus all adjustments made within 60 days of the paid date.
- In States with date-specific eligibility, the agency would associate all payments for services received in the first 30 days of eligibility (strata one and two cases).
  Example: An applicant applies for Medicaid and is eligible on January 15th. the State makes eligibility effective January 15th. The State would collect payments for services received in the first 30 days of eligibility, beginning January 15th and paid from January 15th through February , March, April, and May plus all adjustments made within 60 days of the paid date.
- For all cases in stratum three, the agency would associate all payments for services received in the sample month.
  Example: A case is sampled in stratum three in January. The State would collect payments for services received in January and paid in January, February, March, April and May plus all adjustments made within 60 days of the paid date.

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. (SCHIP has no retroactive eligibility period). For beneficiaries who are provided coverage for this retroactive period, States should not collect payments made during that timeframe. .

Also, 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 one (applications) and two (redeterminations) cases or in the sample month for stratum three "all other cases" 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.

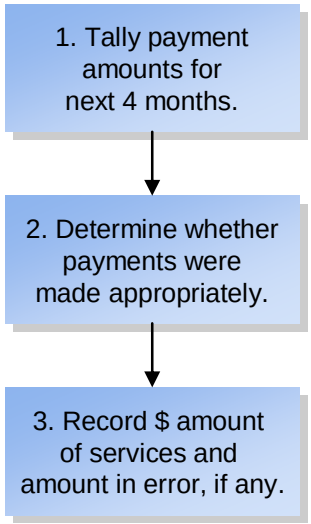
5.1. Instructions for Conducting Medicaid and SCHIP Payment Reviews

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

Step 1. Collect claims and capitation payments for services received within the:

a. The review month or the first 30 days of eligibility for strata one and two cases (applications and redeterminations) according to the State's policy on effective date of eligibility , or;
b. Sample month for stratum three (all other cases).

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



Example: A beneficiary in a State that grants full-month coverage is sampled in stratum one 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.***

Five Month Payment Collection Falling Outside the Fiscal Year								
FY 2007				FY 2008				
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	

Step 2. Verify whether the payments were made appropriately based on the eligibility review findings. The payment review may include determining if 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 was 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 determination of eligible should be counted as correct. Managed care cases that are eligible for Medicaid or SCHIP 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 dollars attributable to the entire case, the amount of correct payments and the amount of dollars in error, if any (see Section 7). 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 review month, first 30 days of eligibility or the sample month, as appropriate, and record the amount for each undetermined case. NOTE: Payments collected for cases found to be "undetermined" should not be included in the error rate calculation but should be reported on the Detailed Payment Review Findings Submission Report.

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.

The State must calculate the eligibility error rates for each program and report in accordance with Section 7. This section describes the calculation of the error rate, its variance, and a confidence interval around the error rate estimate for both active and negative cases. A total of three error rates will be calculated for Medicaid and for SCHIP.

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.

For undetermined active cases:

- 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.

6.1 Calculating 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 for estimating the error rate is called the combined ratio estimator. [4] The payment amounts and amounts of payments in error associated with a case consist of all the fee-for-service claims incurred by the case with a date of service in the sample month, the review month or the first 30 days of eligibility, as appropriate, and that were paid through that month and the following four-month period. Managed care payments consist of all managed care payments made on behalf of the case for coverage of services in the applicable month the case was sampled. The basic strategy of the combined ratio estimator is to estimate total errors and total payments based on the sample information. The sampling frequencies are used to project errors and payments observed in the sample 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.

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[4] For additional discussion of the combined ratio estimator, see for example, William G. Cochran, *Sampling Techniques*, third edition, Wiley Series in Probability and Mathematical Statistics, 1977, p. 165–167.

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

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

where

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

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

m_k is the number of cases sampled from stratum k,

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

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

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

"a" represents the number of strata, which in this case is 27 (nine months for each of initial, redetermined, and other cases).

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

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

and

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

where

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

E_S are the total projected errors from major strata S, and

P_S are the total projected payments from major strata S.

Then,

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

For FY 2007, the sample of cases will be drawn over a nine month period. For FY 2008 and beyond, the sample of cases will be drawn over a twelve month period.

Then, estimated variance is given by

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

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

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

6.2 Calculating Active and Negative Case Error Rates

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

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

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

where

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

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

m_k is the number of cases sampled from stratum k;

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

e_{kl} is a 1 if the lth case in the kth stratum is in error, 0 otherwise;

p_{kl} is a 1 for the lth case in the kth stratum; and

"a" represents the number of strata, which in this case is nine months for negative cases, and 27 for active cases (nine months for each of the three major strata).

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

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

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

where

$\hat{\Pi}$ is the estimated error rate;
q_i is equal to 1 if the sampled case, i, is in error and equal to 0 if sampled case was correctly determined; and
m is the sample size.

The sampling variance of this estimator is

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

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

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

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 SCHIP sampling plan, based on the universes of beneficiaries in the program and persons whose benefits were denied or terminated ;
- On the 15th 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 150th 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 and the eligibility error rates 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, Active Case Review Findings, Negative Case Review Findings, Active Case Payment Findings) for each sample month using the PETT website and the corresponding Excel spreadsheets. States should also submit the final Summary Report and Error Rate Calculation form via the PETT website. The materials and instructions for the using the PETT website as well as the Excel spreadsheets are available on the website (https://www.cmspett.org).

PETT will serve as a vehicle for States to submit their eligibility reporting forms and allows for a central depository for all State-submitted reports. The PETT has two main purposes:

1. Facilitating the accuracy of State reporting by using an electronic process (e.g., reduces potential for user errors in data entry or copying data files, allows for data to be entered only once).

2. Providing accurate data for error rate calculation and corrective action analysis. The site will allow data to be easily exported for error rate calculation at the end of the cycle.

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 attached in Appendix I will upload the data to the PETT website. In order to upload data, States will need to save a copy of the file on a local computer and use the same Excel template throughout the review process (i.e., State will use one Excel template for January, one for February, 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. The PETT Website Instructions and User Guide is Appendix I.

7.1 Sampling Plan

The sampling plan, which must contain the information shown in Exhibit 7.1, is due by August 1st 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 7.1: Sampling Plan Content

Eligibility Sampling Plan for [State] **Program: [Medicaid or SCHIP]** **Fiscal Year [Year]** **Independent Entity [Agency]**
The State must 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: a. how the monthly sample will be drawn; b. how cases will be selected including the method used to randomly select cases; c. the number of cases that will be over sampled to account for fraud cases inappropriately included in the sample. 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 of claims and managed care payments associated with the cases sampled will be obtained. 6. Projected monthly sample size for each stratum. 7. 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. 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.

7.2 Monthly Submission of Sampled Cases

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 the negative cases, for which there is only one stratum. See Appendix H for the reporting form to be completed and submitted to CMS by the 15th day following the sample month and before the reviews begin.

7.3 Eligibility Findings

Detailed eligibility findings for active and negative case reviews are recorded and are due within 150 days of the end of each sample month for 100 percent of the cases reviewed that month. The Active Case Payment Findings form is due within 210 days of the end of each sample month for 100 percent of the cases reviewed in that month.

7.4 Medicaid and SCHIP Error Rate

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

- State-specific case error rate percentages as well as payment error rate percentages and amounts for active cases;
- State-specific case error rate percentages for negative cases; and
- Number of cases and payment amounts for undetermined cases.

The active and negative case error rates, the variances and standard errors of the error rates, and a 95 percent confidence interval around that error rate will be calculated according to the methods described above and submitted to CMS's statistical contractor. CMS can provide an error rate calculator with instructions that States can opt to use to calculate the error rate. When the agency enters the data on eligibility review outcomes, the sample sizes, and the universe sizes, the spreadsheet will calculate the error rate, standard error of the estimate, and a 95 percent confidence interval. It will also

calculate payment dollars in error for the active cases. States that choose to use this error rate calculator must submit a copy of the completed spreadsheet electronically to the CMS statistical contactor no later than July 1 following the Federal fiscal year.

For the active error rate calculations (payment error rate and case error rate), the agency will enter into the spreadsheet the following data for each case by stratum (application, redetermination, and all other cases) and sample month:

- Total payment amounts for the case (dollar sum of claims/managed care payments for that case),
- Total dollars in error for that case due to eligibility error (enter zero if no eligibility payment error exists), and
- Total cases in that stratum in the universe for that month.

For the negative case error rate calculation, the agency will enter into the spreadsheet the following data for each sample month:

- Number of cases sampled,
- Number of cases in error, and
- Number of cases in the universe for that month.The above information is sufficient to calculate the active case payment error rate (dollar weighted) and dollars in error and the active and negative case error rates (not dollar weighted), along with confidence intervals for the estimates.

FY 2007 Timeline for Medicaid and SCHIP Eligibility

1st Quarter			2nd Quarter			3rd Quarter				4th Quarter	
October	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**
	States submit Sampling Plans (11/15)	CMS works with States on Sampling Plans if needed	CMS approves plans (1/15)	Select January sample	Select February sample	Select March sample	Select April sample	Select May sample	Select June sample	Select July sample	Select August sample
Interim Final Rule effective (10/1)			States take actions to implement PERM eligibility reviews	Submit January sample list 2/15	Submit February sample list 3/15	Submit March sample list 4/16	Submit April sample list 5/15	Submit May sample list 6/15	Submit June sample list 7/16	Submit July sample list 8/15	Submit August sample list 9/17
				Begin January reviews	Begin February reviews	Begin March reviews	Begin April reviews	Begin May reviews	Begin June reviews	Begin July reviews	Begin August reviews
									Complete January eligibility reviews	Complete February eligibility reviews	Complete March eligibility reviews
States design forms, staff-up, and begin other start-up activities.								Collect January claims	Collect February claims	Collect March claims	Collect April claims
										Complete January payment reviews 8/15	Complete February payment reviews 9/17
										FY 2008 States submit sampling plans (8/1)	

FY 2008 Timeline for Medicaid and SCHIP Eligibility

1st Quarter			2nd Quarter			3rd Quarter				4th Quarter	
October	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**
Select September sample									Error rates and findings due (7/1)	FY 2009 States submit sampling plan (8/1)	Report rate in FY 2008 PAR
Submit September sample list 10/15										National Eligibility Rate Calculated (8/30)	
Begin September reviews								Calculate State case and payment error rates and compile findings			
Complete April eligibility reviews	Complete May eligibility reviews	Complete June eligibility reviews	Complete July eligibility reviews	Complete August eligibility reviews	Complete September eligibility reviews						
Collect May claims	Collect June claims	Collect July claims	Collect August claims	Collect September claims							
Complete March payment reviews 10/15	Complete April payment reviews 11/15	Complete May payment reviews 12/17	Complete June payment reviews 1/15	Complete July payment reviews 2/15	Complete August payment reviews 3/17	Complete September payment reviews 4/15					
CMS approves FY 08 sampling plans											

***States should complete reviews w/in 105 days; 95% w/in 125 days; and 100% w/in 150 days of end of sample month. Payment review completion deadlines will be 60 days from first day of claims collection month.**

Appendix A: Eligibility Review Process Timeline

Fiscal Year 2008 and Beyond Timeline for Medicaid and SCHIP Eligibility

FFY 1st Quarter			FFY 2nd Quarter			FFY 3rd Quarter			FFY 4th Quarter		
October	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**
States take action to implement PERM eligibility reviews	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 11/15	Submit November sample list 12/15	Submit December sample list 1/15	Submit January sample list 2/15	Submit February sample list 3/15	Submit March sample list 4/15	Submit April sample list 5/15	Submit May sample list 6/15	Submit June sample list 7/15	Submit July sample list 8/15	Submit August sample list 915
	Begin October reviews	Begin November reviews	Begin December reviews	Begin January reviews	Begin February reviews	Begin March reviews	Begin April reviews	Begin May reviews	Begin June reviews	Begin July reviews	Begin August reviews
				Complete 90% of October reviews	Complete 90% of November reviews	Complete 90% of December reviews	Complete 90% of January reviews	Complete 90% of February reviews	Complete 90% of March reviews	Complete 90% of April reviews	Complete 90% of May reviews
					Complete 95% of October reviews	Complete 95% of November reviews	Complete 95% of December reviews	Complete 95% of January reviews	Complete 95% of February reviews	Complete 95% of March reviews	Complete 95% of April reviews
						Complete 100% of October reviews	Complete 100% of November reviews	Complete100% of December reviews	Complete 100% of January reviews	Complete 100% of February reviews	Complete 100% of March reviews
					Collect claims paid for October cases	Collect claims paid for November cases	Collect claims paid for December cases	Collect claims paid for January cases	Collect claims paid for February cases	Collect claims paid for March cases	Collect claims paid for April cases
							Complete October payment reviews	Complete November payment reviews	Complete December payment reviews	Complete January payment reviews	Complete February payment reviews

Fiscal Year 2008 Timeline for Medicaid and SCHIP Eligibility

FFY 1st Quarter			FFY 2nd Quarter			FFY 3rd Quarter			FFY 4th Quarter		
October	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**
Select September sample							Calculate State case and payment error rates and compile findings				
Submit September sample list 10/15											
Begin September reviews									**Error rates and summary finding due 7/1**		
Complete 90% of June reviews	Complete 90% of July reviews	Complete 90% of August reviews	Complete 90% of September reviews								
Complete 95% of May reviews	Complete 95% of June reviews	Complete 95% of July reviews	Complete 95% of August reviews	Complete 95% of September reviews							
Complete100% of April reviews	Complete 100% of May reviews	Complete 100% of June reviews	Complete 100% of July reviews	Complete 100% of August reviews	Complete 100% of September reviews						
Collect claims paid for May cases	Collect claims paid for June cases	Collect claims paid for July cases	Collect claims paid for August cases	Collect claims paid for September cases							
Complete March payment reviews	Complete April payment reviews	Complete May payment reviews	Complete June payment reviews	Complete July payment reviews	Complete August payment reviews	Complete September payment reviews					

Appendix B: Glossary

Active case – A case containing information on a beneficiary who is enrolled in the Medicaid or SCHIP 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 SCHIP eligibility determinations under PERM and excludes the State agency as defined below.

Application – An application form for Medicaid or SCHIP 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 SCHIP 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.

Case error rate - An error rate that reflects the number of cases in error in the eligibility sample for the active cases plus 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.

Eligibility – Meeting the State's categorical and financial criteria for receipt of benefits under the Medicaid or SCHIP programs.

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

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

Medicaid – A joint Federal and State program, authorized 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.

Appendix B: Glossary

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 SCHIP beneficiary for which there is Medicaid or SCHIP Federal financial participation. It may also mean a direct payment to a Medicaid or SCHIP beneficiary in limited circumstances permitted by CMS regulation or policy.

Payment Error Rate – An annual estimate of improper payments made under Medicaid and SCHIP 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 payment in Medicaid and SCHIP.

Payment review - The process by which payments 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.

Sample month – The month the State selects a case from the sample for an eligibility review.

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

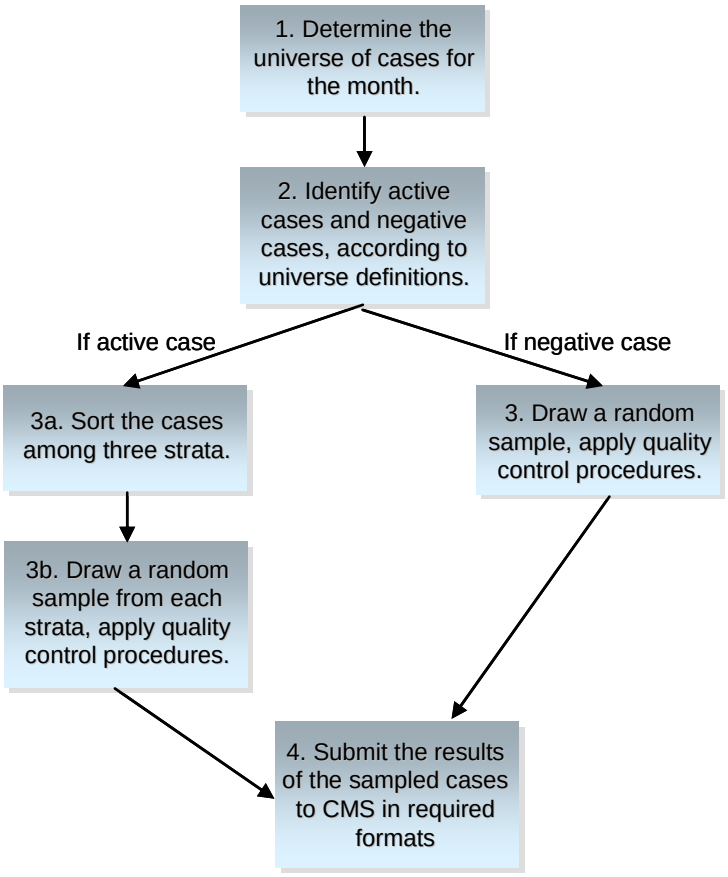
State Children's Health Insurance Program (SCHIP) – A program authorized and funded under title XXI of the Act. Federal regulations governing this program are at 42 CFR Part 457.

SCHIP universe – Cases where all services are paid with title XXI funds including Medicaid-expansion cases that are funded under SCHIP.

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 3.3.

Undetermined - A beneficiary case subject to a Medicaid or SCHIP eligibility determination under PERM about which a definitive determination of eligibility 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*").

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

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

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

Then, the error rate can alternatively be written as,

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

The variance of $\hat{R}$ is given by,

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

Assume,

Appendix D: Active Case Eligibility Sample Size

$$E(P_{ij}) = \mu_{P_i}$$
$$Var(P_{ij}) = \sigma^2_{P_i}$$

Now,

$$Var\left(\sum_j X_{ij}P_{ij}\right) = Var\left(E\left(\sum_j X_{ij}P_{ij}\middle|X_{ij}\right)\right) + E\left(Var\left(\sum_j X_{ij}P_{ij}\middle|X_{ij}\right)\right)$$
$$= Var\left(\sum_j X_{ij}\mu_{P_i}\right) + E\left(\sum_j X_{ij}^2\sigma^2_{P_i}\right)$$
$$= \mu^2_{P_i}\sum_j Var(X_{ij}) + \sigma^2_{P_i}\sum E\left(X_{ij}^2\right)$$
$$= \mu^2_{P_i}n_i\sigma^2_{X_i} + \sigma^2_{P_i}n_i\left(\sigma^2_{X_i} + \mu^2_{X_i}\right)$$
$$= n_i\left(\mu^2_{P_i}\sigma^2_{X_i} + \sigma^2_{P_i}\sigma^2_{X_i} + \sigma^2_{P_i}\mu^2_{X_i}\right)$$

Then,

$$Var(\hat{R}) = \frac{\sum_i w_i^2 Var\left(\sum_j X_{ij}P_{ij}\right)}{P^2}$$
$$= \frac{\sum_i \frac{N_i^2}{n_i^2} n_i \overbrace{\left(\mu^2_{P_i}\sigma^2_{X_i} + \sigma^2_{P_i}\sigma^2_{X_i} + \sigma^2_{P_i}\mu^2_{X_i}\right)}^{\xi_i}}{P^2}$$

By Neyman-Pearson optimal allocation,

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

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

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

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

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

Appendix D: Active Case Eligibility Sample Size

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

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

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

The margin of error, *d*, is thus

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

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

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

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

Considering all the factors discussed above and to keep computation simple, we use the formula for a simple random sample, even if doing so would give an overestimate for the sample size.

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

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

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

Appendix D: Active Case Eligibility Sample Size

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

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

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

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

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

For a simple random sample,

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

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

Hence,

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

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

Hence, for a simple random sample

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

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

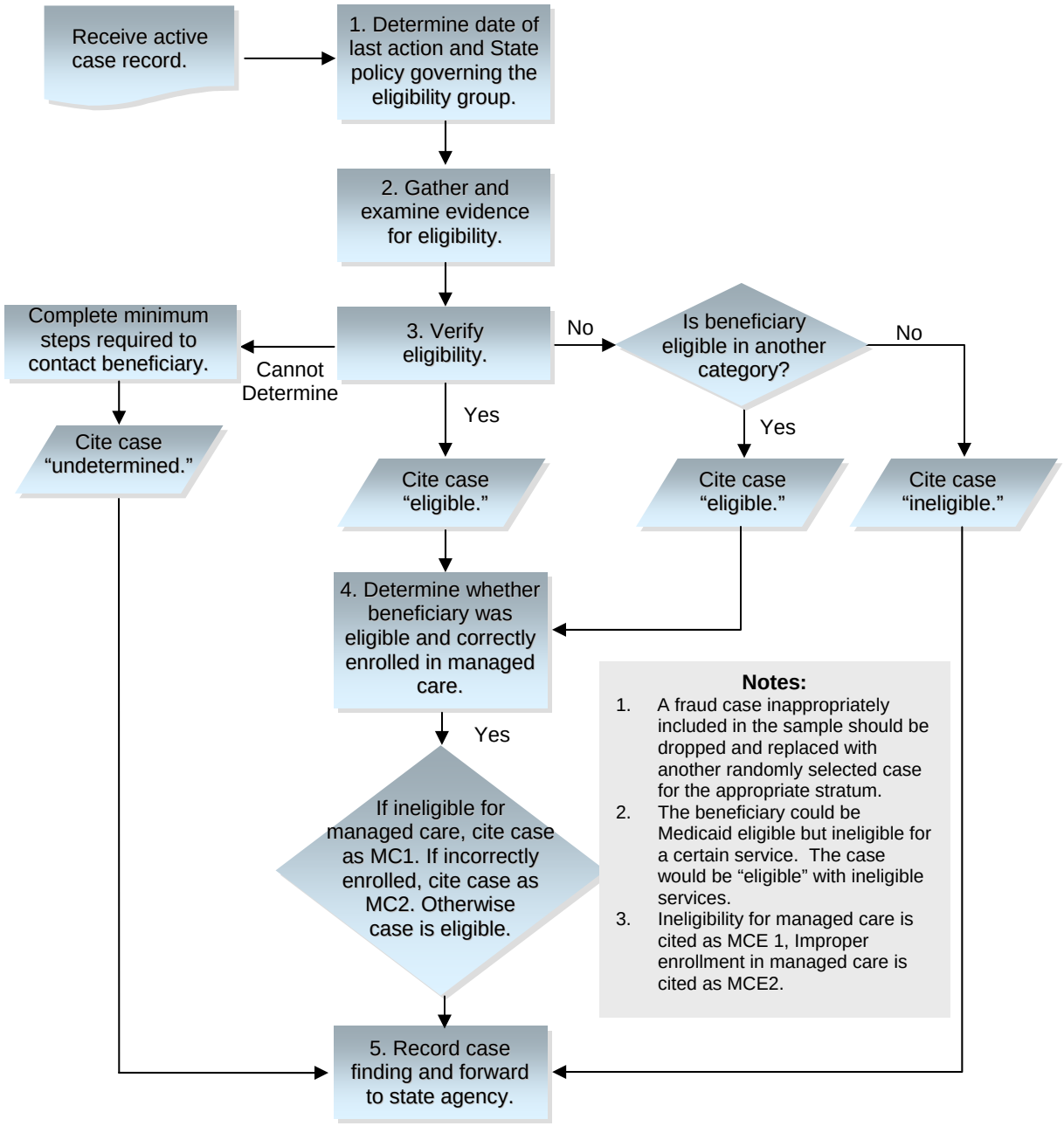
$$= \frac{z_{\alpha/2}^2}{d^2}\left(\left(1+K^2\right)\pi(1-\pi) + K^2\pi^2\right) \text{ (substituting } \hat{\mu}_P = \overline{P}\text{)}$$

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

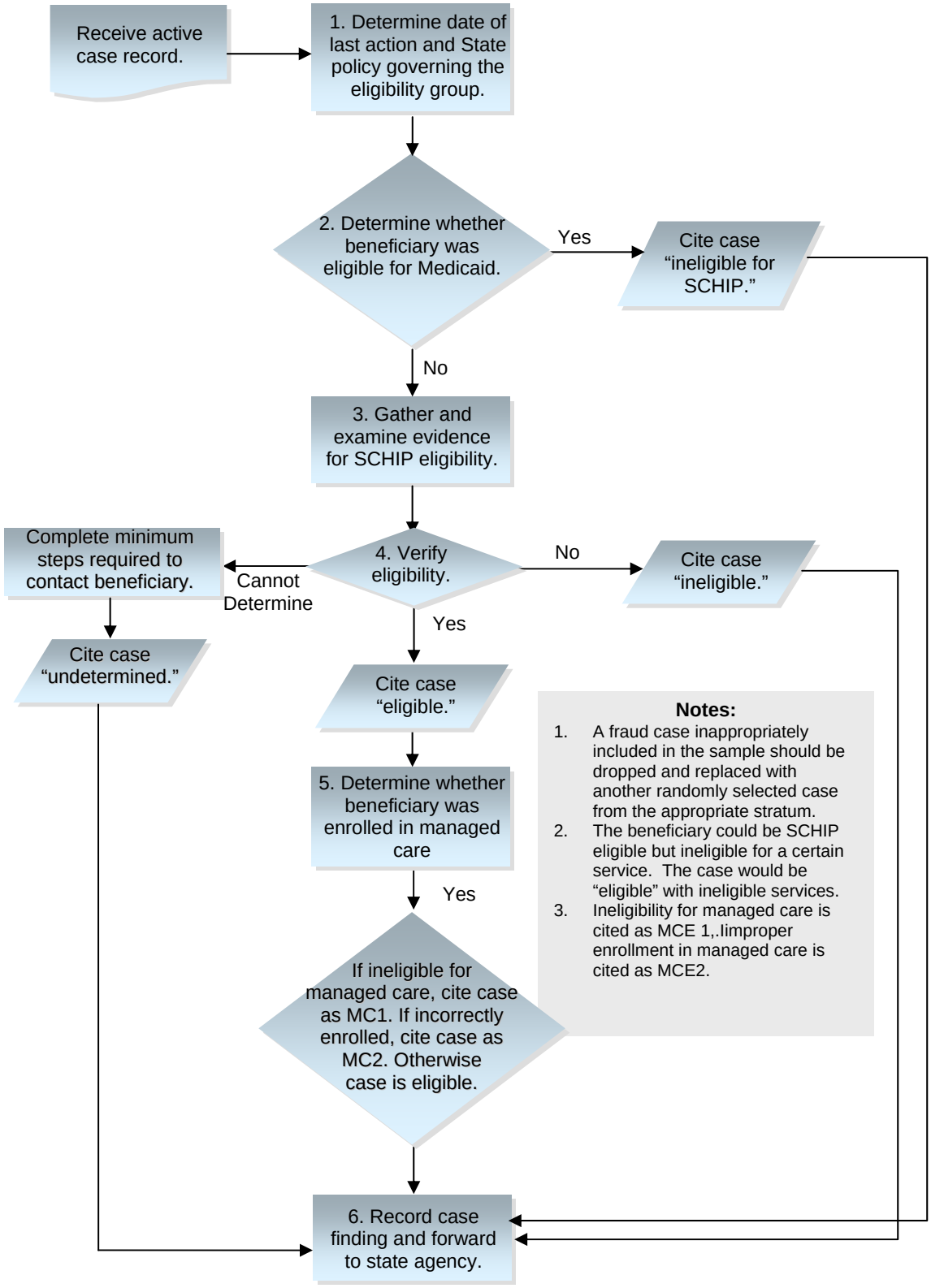
- α = 0.05
- d = 0.03 (3.0 percentage points)

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

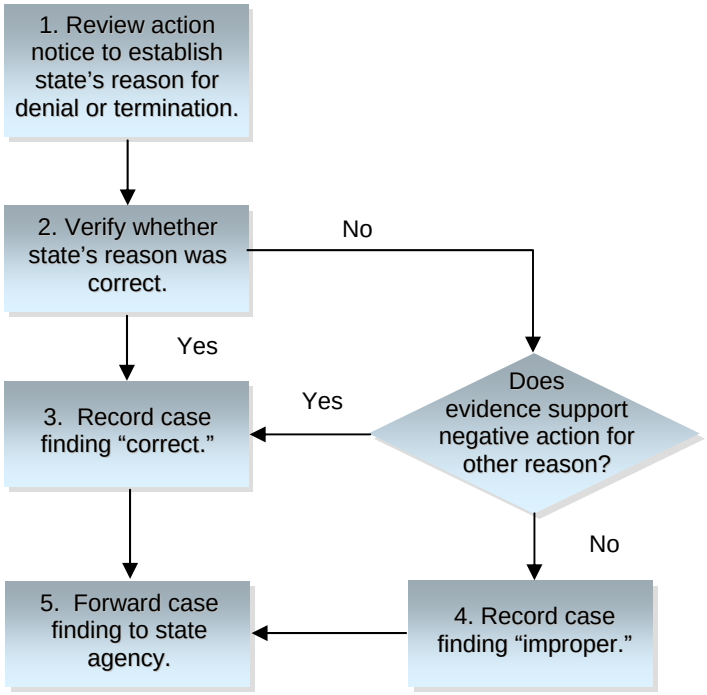
Appendix E: Medicaid Active Case Review Process



Appendix F: SCHIP Active Case Review Process



Appendix G: Medicaid and SCHIP Negative Case Review Process



Appendix G: Medicaid and SCHIP Negative Case Review Process

Instructions for Completing the PERM Eligibility Reviews: Cases Selected for Review: Monthly Sample Selection List

Purpose: These instructions provide guidance on completing the monthly sample selection list. The monthly sample selection list provides the base level information about the cases

that have been randomly selected for the given sample month. States submit one monthly Sample Selection List Report for each month in the sampling timeframe. Both active and negative cases that are sampled in a given month are included on each monthly form.

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 by Line Instructions

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., June 15, 2007).

Line C: Program

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

Line D: Sample Month and Year

Enter the month and year for which the sample was drawn from the universe, e.g., January 2007. "Universe" refers to the total number of cases in the sample month. The universe will be unique for each month.

Appendix G: Medicaid and SCHIP Negative Case Review Process

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

Enter the total number of active cases (per stratum) and negative cases in the universe during the sample month. 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 (see below). The negative universe is the total number of cases that have either been denied or terminated in the given sample month. For active cases, include the number of cases in each stratum in the respective column as follows:

- **Stratum 1 Applications** - A case constitutes an "application" for the sampling month if the State took an action to grant eligibility in that month based on a completed application. States should count an individual reapplying for Medicaid or SCHIP after a break in eligibility as a new application and place the case in stratum one.
- **Stratum 2 Redeterminations** - A case constitutes a "redetermination" for the sampling month if the State took an action to continue eligibility in the sample month based on a completed redetermination.
- **Stratum 3 All Other Cases** - All other cases (properly included in the universe but do not meet the strata one or two criteria) that are on the program in the sample month are placed in stratum three.
- **Negative Cases** - A negative case contains information on a beneficiary whose application for benefits was denied or whose program benefits were terminated by the State.

Appendix G: Medicaid and SCHIP Negative Case Review Process

Line F: Case/ Beneficiary 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 that 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, and Stratum 3). For each case selected for the sample of negative cases, list the case ID in the Negative Cases column.

Add rows on an attachment if the number of cases in the sample in any column exceeds the number of rows provided.

Provide the total number of cases sampled in each stratum for active cases and the total number of cases sampled for negative case reviews at the bottom of each row.

Appendix H: Eligibility Reporting Forms

Form Approved
OMB No. 0938-1012

Payment Error Rate Measurement (PERM) Eligibility Reviews:

Cases Selected for Review: Monthly Sample Selection List

Due on the 15th day of the month after the sample month and before the eligibility reviews begin.

Monthly Sample Selection List				
A. State				
B. Date				
C. Program				
D. Sample Month & Year				
E. Number of cases in universe that month	**Stratum 1 Applications**	**Stratum 2 Redeterminations**	**Stratum 3 All Other Cases**	**Negative Cases**
F.	**Case/Beneficiary Identification**	**Case/ Beneficiary Identification**	**Case/ Beneficiary Identification**	**Case/ Beneficiary Identification**
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				
15)				
16)				
17)				
18)				
19)				
20)				
21)				
22)				
23)				

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1012. The time required to complete this information collection is estimated to average 100 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS-10184A

Appendix H: Eligibility Reporting Forms

Instructions for Completing the PERM Eligibility Reviews: Detailed Review Findings for Active Case Reviews

Purpose: The detailed active case review findings form provides detailed information about findings from the eligibility reviews of active cases identified on the monthly sample selection list for each sample month. This form is submitted for each month in the sampling timeframe for the sample of active cases. 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).

An "active case" is a case containing information on a beneficiary who was enrolled in the Medicaid or SCHIP program in the sample month. The active case universe includes all active cases on the rolls from the first day of that month through the last day of the month, with the exception of:

- *Negative cases - all cases that were denied or terminated,*
- *Cases that are under active beneficiary fraud investigation,*
- *Supplemental Security Income cases in 1634 States, and*
- *Title IV-E adoption assistance and foster care cases.*

Line by Line Instructions

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, 2007).

Appendix H: Eligibility Reporting Forms

Line C: Program

Enter the program for which the monthly Detailed Active Case form applies (e.g., Medicaid or SCHIP).

Line D: Sample Month and Year

Enter the month and year 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 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 strata 3, the timeframe for verifying eligibility could differ. Generally, eligibility also 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 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.

- **Dropped Due to Beneficiary Fraud**

"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 cases under active beneficiary fraud investigation 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. If a case was dropped from the sample due to an active beneficiary fraud investigation, note the date the case was dropped (e.g., 6/15/07). If the case was not dropped, leave this column blank.

- **Stratum**

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

- **Stratum 1 - Applications** - A case constitutes an "application" for the sampling month if the State took an action to grant eligibility in that month based on a completed application. States should count an individual reapplying for Medicaid or SCHIP after a break in eligibility as a new application and place the case in stratum one.
- **Stratum 2 - Redeterminations** - A case constitutes a "redetermination" for the sampling month if the State took an action to continue eligibility in the sample month based on a completed redetermination.
- **Stratum 3 - All Other Cases** - All other cases (properly included in the universe but do not meet the strata one or two criteria) that are on the program in the sample month are placed in stratum three.

- **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 –** An individual beneficiary meets the State's categorical and financial criteria for receipt of benefits under the program.
- **EI - Eligible with ineligible services –** An individual beneficiary meets the State's categorical and financial criteria for receipt of benefits under the Medicaid or SCHIP programs but was not eligible to receive particular services. An example of "eligible with ineligible services" would be a case where the beneficiary did not fully pay his share of cost. Another example would be a person eligible under the medically needy group who received services not provided to the medically needy group.

- **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.
- **U - Undetermined -** A beneficiary case subject to a Medicaid or SCHIP eligibility determination under PERM about which a definitive determination of eligibility 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.
- **L/U - Liability understated –** Beneficiary paid too little toward his liability amount or cost of institutional care and the State paid too much.
- **MCE1 - Managed care error, ineligible for managed care –** Upon verification of residency and program eligibility, and the beneficiary is enrolled in managed care but is not eligible for managed care.
- **MCE2 - Managed care error, eligible for managed care but improperly enrolled –** Beneficiary is eligible for both the program and for managed care but not enrolled in the correct managed care plan as of the month eligibility is being verified.

- **Cause of Error, if known -** Enter the cause of the error, if known, 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.

Form Approved
OMB No. 0938-1012

Payment Error Rate Measurement (PERM) Eligibility Reviews: Detailed Review Findings for Active Case Reviews

Due within 150 days from the end of each sample month.

A. State	
B. Date	
C. Program	
D. Sample Month & Year	

E. Case ID	Review Month	Dropped Due to Beneficiary Fraud	Stratum 1,2 or 3	Review Finding E -eligible EI-eligible with ineligible services NE- not eligible U –undetermined L/O – liability overstated L/U - understated MCE1 – managed care error, ineligible for managed care MCE2 – eligible for managed care but improperly enrolled	Cause of Error, if known Example: excess income, non-resident.
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					
13)					
14)					
15)					
16)					
17)					
18)					
19)					
20)					

Appendix H: Eligibility Reporting Forms

Instructions for Completing the PERM Eligibility Reviews:

Detailed Findings for Negative Case Reviews

Purpose: These instructions provide guidance on completing the Detailed Negative Case Review form. This form provides detailed information about findings from the review of negative cases in the monthly sample. 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).

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

The negative case universe includes all cases that were denials of eligibility in a given month and all active cases that were found to be ineligible and moved from active to negative in the month.

Line by Line Instructions

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 Findings form is being submitted to CMS (e.g., June 15, 2007).

Line C: Program

Enter the program for which the monthly Detailed Negative Case form applies (e.g., Medicaid or SCHIP).

Appendix H: Eligibility Reporting Forms

Line D: Sample Month and Year

Enter the month and year 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 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 that 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**

Denial – Means an application was completed by the beneficiary but was rejected for not meeting eligibility requirements.

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.

Line E - continued

- **Review Finding**

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

- **C - Correct –** The negative case was properly denied or terminated by the State.
- **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.
- **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, if known**

Enter the cause of the error, if known. 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 H: Eligibility Reporting Forms

Form Approved
OMB No.0938-1012

Payment Error Rate Measurement (PERM) Eligibility Reviews:

Detailed Findings for Negative Cases

Due within 150 days of the end of each sample month.

A. State	
B. Date	
C. Program	
D. Sample Month and Year	

E. Case/ Beneficiary ID	Denial or Termination D – denial T - termination	Review Finding C – correct ID – improper denial IT – improper termination	Cause of Error, if known
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
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20)			
21)			
22)			
23)			

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1012. The time required to complete this information collection is estimated to average 100 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS-10184C

Appendix H: Eligibility Reporting Forms

Instructions for Completing the PERM Eligibility Reviews: Detailed Findings for Payment Review

Purpose: The Detailed Payment Review Findings form provides detailed payment review findings for all cases in each monthly sample. This form identifies the total dollars paid, the amount correctly paid and the amount paid in error for each case, as appropriate, in the sample for a given month.

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 by Line Instructions

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 form* is being submitted to CMS (e.g., June 15, 2007).

Line C: Program

Enter the program for which the monthly Detailed Payment form applies (e.g., Medicaid or SCHIP).

Line D: Sample Month and Year

Enter the month and year 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.

Appendix H: Eligibility Reporting Forms

Line E: Case/ Beneficiary 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.

- **Dropped Due to Beneficiary Fraud**

"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 cases under active beneficiary fraud investigation 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.

If a case was dropped from the sample due to an active beneficiary fraud investigation, note the date the case was dropped (e.g., 6/15/07). If the case was not dropped, leave this column blank.

- **Stratum**

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

- **Stratum 1 Applications** - A case constitutes an "application" for the sampling month if the State took an action to grant eligibility in that month based on a completed application. States should count an individual reapplying for Medicaid or SCHIP

after a break in eligibility as a new application and place the case in stratum one.

➢ **Stratum 2 Redeterminations** - A case constitutes a "redetermination" for the sampling month if the State took an action to continue eligibility in the sample month based on a completed redetermination.

➢ **Stratum 3 All Other Cases** - All other cases (properly included in the universe but do not meet the strata one or two criteria) that are on the program in the sample month are placed in stratum three.

- **Review Finding**

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

➢ **E - Eligible –** An individual beneficiary meets the State's categorical and financial criteria for receipt of benefits under the Medicaid or SCHIP programs.

➢ **EI - Eligible with ineligible services –** An individual beneficiary meets the State's categorical and financial criteria for receipt of benefits under the program but was not eligible to receive particular services. An example would be a person eligible under the medically needy group who received services not provided to the medically needy group.

➢ **NE - Not eligible –** An individual beneficiary is receiving benefits under the program but does not meet the State's categorical and financial criteria.

➢ **U - Undetermined** - A beneficiary case sampled for review under PERM about which a definitive verification of eligibility 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.

- **L/U - Liability understated –** Beneficiary paid too little toward his liability amount or cost of institutional care and the State paid too much.
- **MCE1 - Managed care error, ineligible for managed care –** Upon verification of residency and program eligibility, and the beneficiary is enrolled in managed care but is not eligible for managed care.
- **MCE2 - Managed care error, eligible for managed care but improperly enrolled –** Beneficiary is eligible for both the program and for managed care but not enrolled in the correct managed care plan as of the month eligibility is being verified.

- **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.

For FFS cases, enter the total amount of dollars paid for the beneficiary based on claims for services rendered at any time in the spend down period (if appropriate) through the review month or are rendered in the sample month (for cases in stratum 3) which are paid by the end of the fourth month after the review month (or sample month for cases in stratum 3).

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.

Enter the portion of the payments, in part or in whole as appropriate, that were correct for each sampled case.

Appendix H: Eligibility Reporting Forms

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

  - ineligibility for services received.

  - ineligibility for the program,

  - liability overstated or understated,

  - ineligibility for managed care,

  - 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.

Appendix H: Eligibility Reporting Forms

Form Approved
OMB No. 0938-1012

Payment Error Rate Measurement (PERM) Eligibility Reviews:

Detailed Payment Review Findings

Due within 210 days of the end of each sample month.

A. State	
B. Date	
C. Program	
D. Sample Month & Year	

E. Case ID	Dropped Due to Beneficiary Fraud	Stratum 1,2 or 3	Review Finding E -eligible EI-eligible with ineligible services NE- not eligible U –undetermined L/O – liability overstated L/U - understated MCE1 – managed care error, ineligible for managed care MCE2 – eligible for managed care but improperly enrolled	Payment Amount Correct	Payment Amount in Error

Form CMS-10184D

Appendix H: Eligibility Reporting Forms

Instructions for Completing the PERM Eligibility Reviews: Summary Review Findings and Error Rate

Purpose: The Summary Case Review and Error Rate Form provides summary case review findings from the review of all cases in the monthly active and negative case samples as well as the payment and case error rates, as appropriate. This form provides comprehensive data for active cases (total and for each of the three stratum) and negative cases (total, denials and terminations).

This form is due by July 1st following the fiscal year being measured (i.e., for States completing PERM eligibility reviews for fiscal year 2007, the summary report is due by July 1, 2008).

Line by Line Instructions

Summary Findings Table:

Line A: State

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

Line B: Date

Enter the date that the Summary Case Review and Error Rate form is being submitted to CMS (e.g., Jul y 1, 2008).

Line C: Program

Enter the program for which the Summary Case Review and Error Rate form applies (e.g., Medicaid or SCHIP).

Line D: Total

Enter the total number of cases in each column. For example, in column one, 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 two, enter the total number of cases excluded due to beneficiary fraud.

Appendix H: Eligibility Reporting Forms

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

- **Number of Cases in the Universe Column**

  Enter the number of cases in the universe subject to sampling for the months reviewed throughout the fiscal year.

- **Number of Cases Sampled Column**

Enter the number of cases sampled in each of the categories described in the rows. These should equal the totals reported on the Monthly Sample Selection Lists.

- **Number of Cases Excluded due to Beneficiary Fraud Column**

  Enter the number of cases excluded from the sample due to beneficiary fraud in each of the categories described in the rows. These should equal the number of beneficiary fraud cases reported on the monthly Detailed Active Case Review Findings form.

  The cells should be left blank in the Negative, Denials, and Terminations rows.

- **Number of Cases Eligible Column**

  Enter the number of cases deemed to be eligible through the PERM eligibility reviews 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 findings of "E—eligible," "EI—eligible for 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 eligible through the negative case action reviews throughout the fiscal year as reported on the Detailed Negative Case Review Findings forms (codes ID for incorrect denials and IT for incorrect terminations) .

Appendix H: Eligibility Reporting Forms

- **Number of Cases Ineligible Column**

  Enter the number of cases deemed to be ineligible 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 findings of "NE—not eligible."

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

- **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 cases 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.

Line E: 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 a beneficiary who was enrolled in the program in the sample month.

- **Stratum 1 Applications** - A case constitutes an "application" for the sampling month if the State took an action to grant eligibility in that month based on a completed application. States should count an individual reapplying for Medicaid or SCHIP after a break in eligibility as a new application and place the case in stratum one.

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

Appendix H: Eligibility Reporting Forms

- **Stratum 2 Redeterminations -** A case constitutes a "redetermination" for the sampling month if the State took an action to continue eligibility in the sample month based on a completed redetermination.

  Enter the total 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 one or two criteria) that are on the program in the sample month are placed in stratum three.

Enter the total active cases in Stratum 3, All other cases, sampled for the fiscal year.

Line F: 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.

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 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.

Appendix H: Eligibility Reporting Forms

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.

Total Dollars in Error Column

Enter the total dollars found in error that corresponds 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.

Error Rate Table*:*

Line G: Active Payment Error Rate

Enter the amount represented in the universe in the **Dollar Amount** column.

The active payment error rate is a "dollar weighted" error rate. The dollar value of claims for services provided in the month of eligibility review are used to calculate the payment error rate. Enter the payment error rate as calculated for your State in the **Error Rate** column. Please report the error point with one decimal, e.g., 94.2%.

Appendix H: Eligibility Reporting Forms

Enter the confidence and precision of the computed error rate – which should be 95.0%, +/- 3 % - in the **Confidence and Precision** column.

The **Percentage** column is not applicable and should be left blank.

Line H: Active Case Error Rate

The Active Case error rate is a simple case error rate; therefore, the **Dollar Amount** column is not applicable and should be left blank.

Enter the case error rate as calculated for your State in the **Error Rate** column. Please report the error point with one decimal (e.g., 94.2%).

Enter the confidence and precision of the case error rate - which should be 95.0%, +/- 3 % - in the **Confidence and Precision** column.

The **Percentage** column is not applicable and should be left blank.

Line I: Negative Case Error Rate

The negative case error rate is a simple case error rate (valid or invalid eligibility) for negative cases. Enter the case error rate as calculated for your State in the **Error Rate** column. Please report the error point with one decimal (e.g., 94.2%).

Enter the confidence and precision of the computed case error rate – which should be 95.0%, +/- 3 % - in the **Confidence and Precision** column.

The **Percentage** column is not applicable and should be left blank.

Line J: Undetermined Cases

Appendix H: Eligibility Reporting Forms

Form Approved
OMB No. 0938-1012

Payment Error Rate Measurement (PERM) Eligibility Reviews:

Summary Findings and Error Rate Tables

Due July 1 following the Federal fiscal year being measured.

Summary Findings Table

A. State									
B. Date									
C. Program									
	Number of Cases in Universe	**Number of Cases Sampled**	**Number of Fraud Cases Excluded from the Universe or Sample**	**Number of Cases Eligible**	**Number of Cases Ineligible**	**Number of Cases Undetermined**	**Total Dollars Paid**	**Total Dollars Correct**	**Total Dollars in Error**
D. Total									
E. Active									
Stratum 1									
Stratum 2									
Stratum 3									
F. Negative									
Denials									
Terminations									

	Dollar Amount	**Error Rate**	**Confidence and Precision**	**Percentage**
G. Active Payment Error Rate				N/A
H. Active Case Error Rate	N/A			N/A
I. Negative Case Error Rate	N/A			N/A
J. Undetermined Cases		N/A	N/A	

Error Rate Table

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

Signature: _____ Date: _____
State Medicaid/SCHIP Director or Designee

Appendix I: PERM Eligibility Tracking Tool (PETT) Website Instructions and User Guide

PERM Eligibility Tracking Tool
Eligibility Form Submission Website
https://www.cmspett.org
Website Instructions and User Guide

Appendix I: PERM Eligibility Tracking Tool (PETT) Website Instructions and User Guide

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Appendix I: PERM Eligibility Tracking Tool (PETT) Website Instructions and User Guide

Overview

The PERM Eligibility Tracking Tool (PETT) will serve as a vehicle for States to submit their eligibility reporting forms and allows for a central depository for all State-submitted reports. The PETT has two main purposes:

3. 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, requires data to only be entered once).

4. Providing accurate data for error rate calculation and corrective action analysis. The site will allow data to be easily exported for error rate calculation at the end of the cycle.

The site will allow States to either download a form template and upload the completed form back to the site, 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 below, will upload the data to the PETT website. In order to upload data, States will need to save a copy of the file on a local computer and use the same Excel template throughout the review process (i.e., State will use one Excel template for January, one for February, 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.

If errors are identified in the PERM eligibility universes (e.g., SSI cases are found in the Medicaid universe, State-only funded cases are found in the SCHIP universe, etc.) causing changes to the sample once the monthly sample selection list is sent in, the State cannot change the sample list unless it is due to a statistical matter that would affect the State's error rate (e.g., errors in the universe). No other changes to samples are allowed. States will need to gain CMS approval before resubmitting a revised sample and should contact The Lewin Group with specific information regarding why the sample is being changed. Once the State has gained the necessary approval, the State will need to re-submit the data using a new eligibility reporting form to the website. Re-submitted data will not delete previously submitted data. The database will keep a record of all submitted data. However, only the latest version will be available for a State to view.

States should designate one primary and one secondary staff member to have access to the PETT website. Only two staff members from each State will be able to register for the PETT website and have access to upload or input data.

Note on Beneficiary/Claim ID numbers for PETT site: In order to be HIPAA compliant, States that have beneficiary ID numbers that are not randomly assigned (e.g., Social Security numbers) will need to develop dummy beneficiary ID numbers to submit eligibility reporting forms via PETT. States should develop their own system for developing the dummy beneficiary ID numbers but the numbers should be consistent for each claim throughout the eligibility review process. The dummy ID numbers should be between 6 and 10 characters (e.g., for Pennsylvania Medicaid Stratum One cases: PAMedS101, PAMedS102, etc.) Crosswalks for these dummy claims should be sent in a hard media (e.g., CD) password protected file to CMS when States submit the Monthly Sample Selection List to the PETT website. The crosswalk should be sent to Janet Reichert, Centers for Medicare & Medicaid Services, C3-02-16, 7500 Security Boulevard, Baltimore, MD 21244-1850. The passwords can be emailed to Janet Reichert at janet.reichert@cms.hhs.gov. However, under no circumstances should the crosswalks be emailed directly to CMS due to the inclusion of personal health information. States that already

assign random case ID numbers to beneficiaries will not need to develop dummy ID numbers to be able to submit their eligibility reporting forms via the PETT website.

Registration

The Registration Page (**Exhibit 1**) will allow States to sign-up for access to the PETT site. To register, click on the "Click here to register" link on the Homepage. This will take you to the page to register as a new user.

1. Select your State from the dropdown box.

2. Enter your First Name, Last Name, and Email Address.

3. Enter a Username of your choice (for example firstname.lastname). Your username is case sensitive.

4. Create a password. Passwords must be at least 8 characters in length, and must contain at least one number, one upper case letter, one lower case letter, and one special character (special characters are !#$%&()*+,-./:;<=>?@[\]^_{|}~). Passwords must be changed every 60 days and States should not use the same password more than once. Passwords are case sensitive.

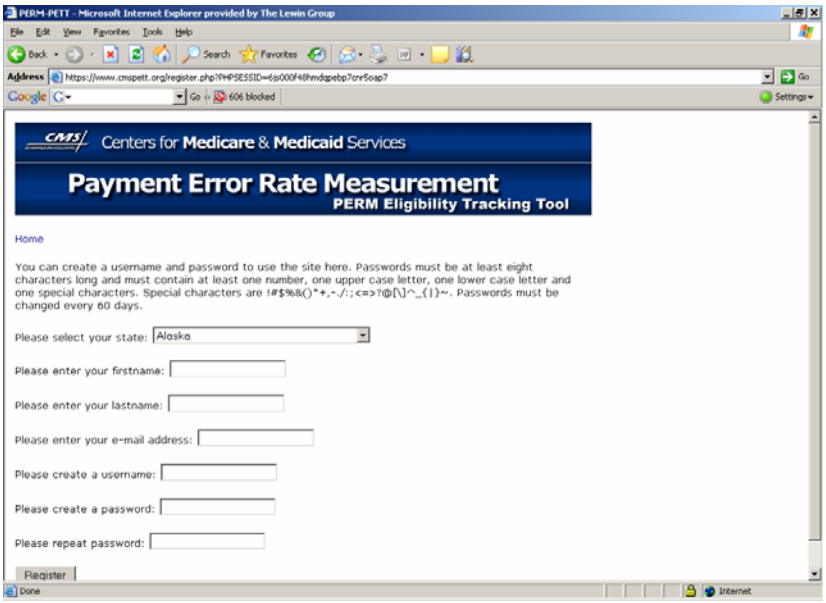
5. Then, re-enter the password.

6. Click on the Register button.

Once you click on the "Register" button, the registration request will be sent to the PETT webmaster at Lewin. We will process your request within one business day by verifying that you are associated with a State participating in the Payment Error Rate Measurement eligibility review for the appropriate fiscal year (State or contractor staff). If your name has not been given to us previously, we will contact the project director of the State you identified to verify that you work on PERM; this may cause the registration process to take a few days. For FY08 States and beyond, please make sure that you register at least one month in advance of the first Monthly Sample Selection List submission due date.

Appendix I: PERM Eligibility Tracking Tool (PETT) Website Instructions and User Guide

Exhibit 1. Registration Page



Once we approve the registration, you will receive an email message that will instruct you to click on a link to the website to confirm the registration. This is a protection against someone else registering with your email address.

Logging In

The ***Log-in*** page (**Exhibit 2**) allows authorized users to sign in to their respective State pages to download eligibility reporting forms, upload eligibility reporting forms, or use the on-line reporting form to enter in data for each sample form. As a reminder, only two authorized users will be permitted to have access to the PETT website and enter reporting information.
To enter your State's site:

1. Go to https://www.cmspett.org.

2. Enter your username and password. Both are case sensitive.

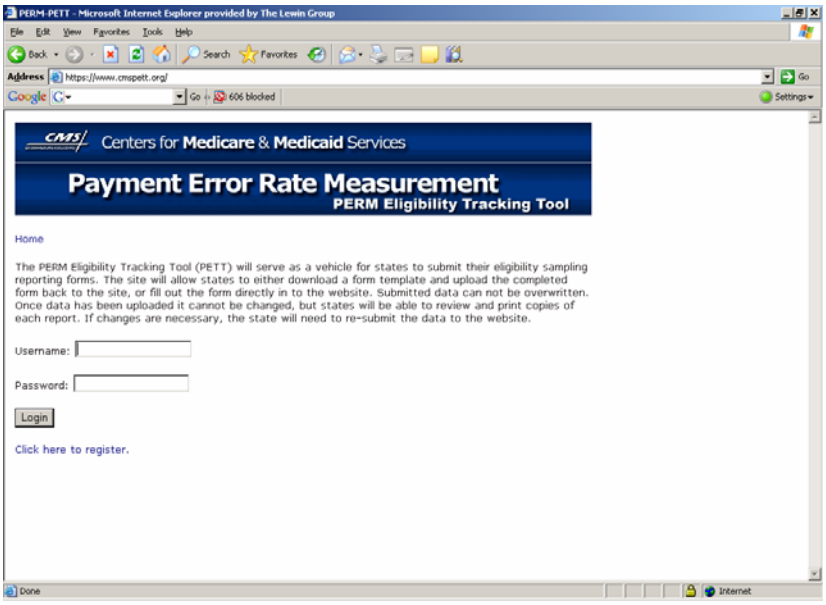
3. Click the log-in button. You will be directed to your State's page.

4. Be sure to click on the "Log-out" button at the end of each session to ensure the security of your State's data.

Note: A username is disabled for fifteen minutes after three consecutive failed login attempts. After three consecutive disable cycles, the username is locked out until reset by the administrator. If your username becomes locked out, please email The Lewin Group at permsc.2007@lewin.com. Three consecutive failed login attempts at the same IP address will lock out that IP address for fifteen minutes. Also, the website will automatically log a user out after being logged on for 60 minutes.

Appendix I: PERM Eligibility Tracking Tool (PETT) Website Instructions and User Guide

Exhibit 2. Log-in Page



Using the Eligibility Reporting Forms

Forms That Can Be Submitted Using PETT

Reporting forms are required for each sample month of the PERM eligibility sampling process to report on the outcomes of sampling, review and payment collection. There are four forms States will submit for each program (Medicaid and SCHIP) to report on each month of the PERM eligibility process and one final summary form (Appendix A).

1. The Monthly Sample Selection List is where States will report the monthly random samples drawn for the active case universe (stratum one, stratum two, and stratum three) and the negative universe. This report is due on the 15th day of the month following each sample month and should be completed before reviews begin.

2. The Detailed Review Findings for Active Case Reviews is where States report on the outcomes of the monthly eligibility reviews for active cases. This form is due 150 days from the end of each sample month.

3. The Detailed Review Findings for Negative Case Reviews form is where States report on the outcomes of the monthly eligibility reviews for negative cases. This form is due 150 days from the end of each sample month.

4. The Detailed Payment Review Findings form is due 210 days from the end of each sample month and is where States report the dollars values associated with the sampled cases.

5. The Summary Findings and Error Rate Tables is due on July 1 following the Federal fiscal year that is being measured. The form includes a summary of findings as well as a reporting of your State program's error rate. In the future, there will be a mechanism added to the PETT website which will allow States to export the data already submitted into the summary form. States can then use the error rate calculator (currently under development)

to calculate the State program's error rate. Please see Appendix C for an FY07 timeline for submitting the PERM eligibility reporting forms.

General Instructions for Submitting Forms

The PETT website will allow two methods for submitting the Medicaid and SCHIP eligibility reporting forms. The first method is to download the forms electronically in Excel format and enter the data. Then, using a macro, export the file into a CSV format to be uploaded. Lewin will provide an Excel template which will include four worksheets, one for each of the following forms: the Monthly Sample Selection List, the Detailed Review Findings for Active Case Reviews form, the Detailed Review Findings for Negative Case Reviews form, and the Detailed Payment Review Findings form. To successfully upload each form, States will need to run various macros described below, depending on which form is being completed.
Each State program (Medicaid and SCHIP) should complete one Excel workbook per sample month. Once a State downloads a PERM Eligibility Reporting Forms Excel workbook, the State should save the file and use the same Excel workbook throughout the eligibility review process for each sample month (e.g., Medicaid and SCHIP programs should each have a total of nine Excel workbook files for the FY 2007 PERM Eligibility Review). In the future, States will use a total of twelve Excel workbook files for each program (Medicaid and SCHIP).
The second method for submitting the Medicaid and SCHIP Sample Selection Reporting Forms is to input the data directly into the PETT. Once data has been entered into the reporting form, the data will be uploaded and available in report form for reviewing and printing.

To Upload the Forms Electronically

1. Using the drop-down box, select the specific PERM eligibility reporting form you are uploading and click on the "Submit" button (**Exhibit 3**).

2. Under Form 1, from the drop-down box "Select Sample Month," select the sample month of the PERM eligibility reporting form you are submitting to the PETT website.

3. From the drop-down box "Select Sample Year," choose the appropriate Federal Fiscal Year.

4. From the drop-down box "Select Program," choose the appropriate program, Medicaid or SCHIP.

5. Then, using the "Browse" button, upload the specified PERM Eligibility Reporting form in CSV format.

Note: The file must be saved as a CSV using the macro instructions below. Saving the file as a CSV from Excel will not allow the document to upload correctly. States should run the macro described below to create a CSV file of the report being submitted and then upload the CSV file to the PETT website.

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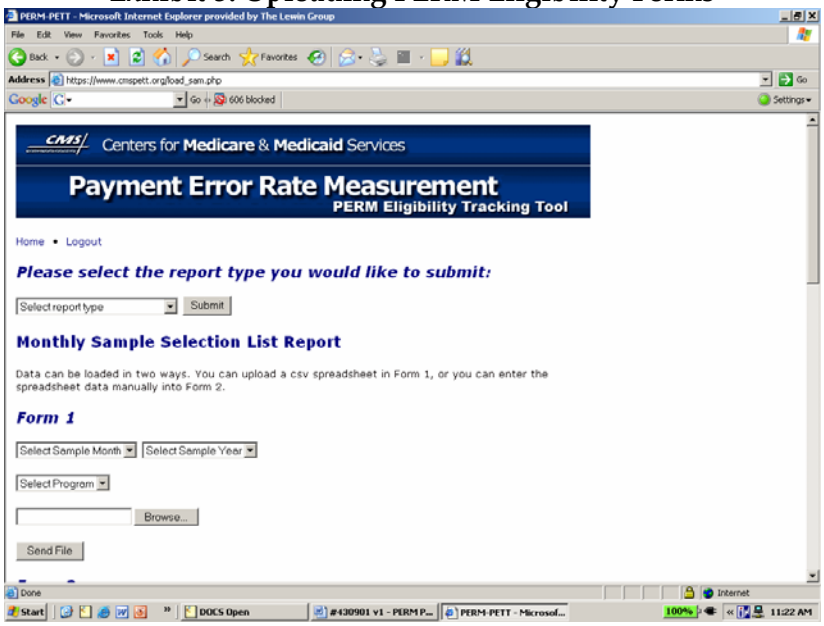
Exhibit 3. Uploading PERM Eligibility Forms



To Directly Input Data into the PETT Website

1. Using the drop-down box, select the specific PERM eligibility reporting form you are uploading and click on the "Submit" button.

2. Under Form 2, from the drop-down box "Select Sample Month," select the sample month of the PERM eligibility reporting form you are submitting to the PETT website.

3. From the drop-down box "Select Sample Year," choose the appropriate Federal Fiscal Year.

4. From the drop-down box "Select Program," choose the appropriate program, Medicaid or SCHIP.

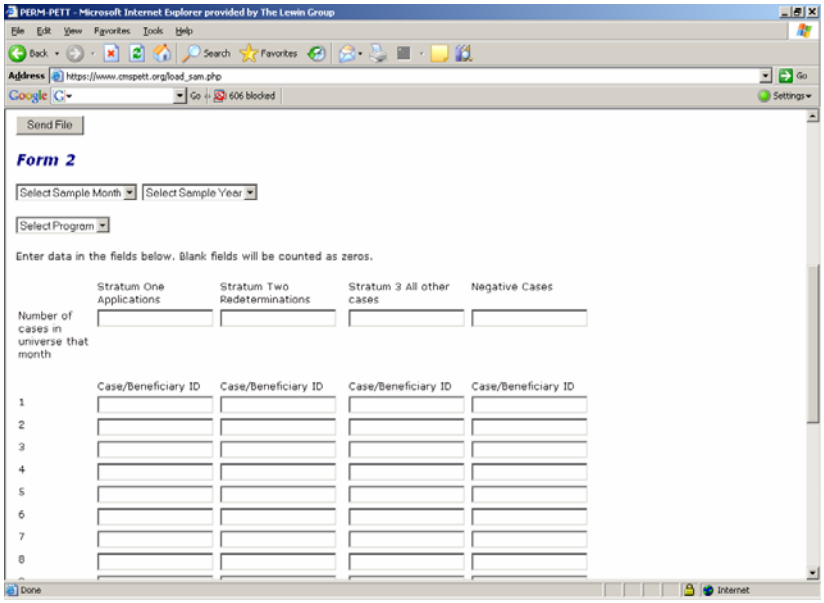
5. Under Form 2, enter in the data appropriate to the PERM eligibility reporting form you are submitting. For example, to complete the Monthly Sample Selection List (**Exhibit 4**), enter in the total number of cases in the respective universe and stratum in the first row of fields under each Active Universe Stratum and the Negative Universe. In the remaining fields, under each Active Universe Stratum and the Negative Universe, enter in the Case/Beneficiary ID for each sampled case. Please note that States that have beneficiary ID numbers that are not randomly assigned (e.g., Social Security numbers) will need to develop dummy beneficiary ID numbers to submit eligibility reporting forms via PETT.

6. Once all fields have been populated, click on the "Submit" button. The data will be uploaded to the site.

7. In order to populate repeated fields in the remaining eligibility worksheets, when a State uses the online form to submit Active Case Reviews, Negative Case Reviews, or Payment Review Findings, click on the appropriate links for the Monthly Sample Selection List with the sample date and program of previously completed monthly reports (located under the **Form 2** heading). Clicking on one of these links will populate the fields with the beneficiary

IDs and strata from the Monthly Sample Selection List. For the Payment Review Findings, clicking the appropriate link for the Active Case Review Findings will populate the fields "Dropped Due to Beneficiary Fraud" and "Review Findings" from the Active Case Review form.

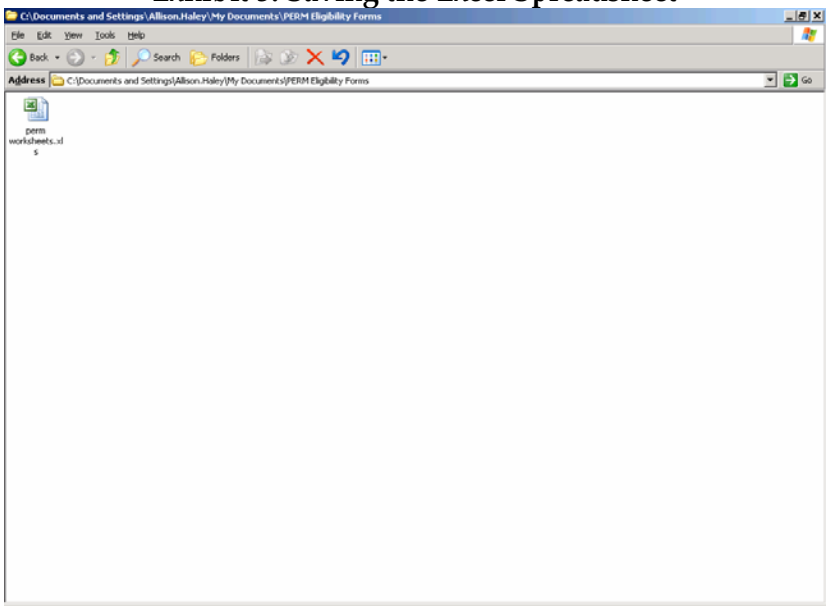
Exhibit 4. Direct Input into the PETT website



Saving and Exporting the Forms

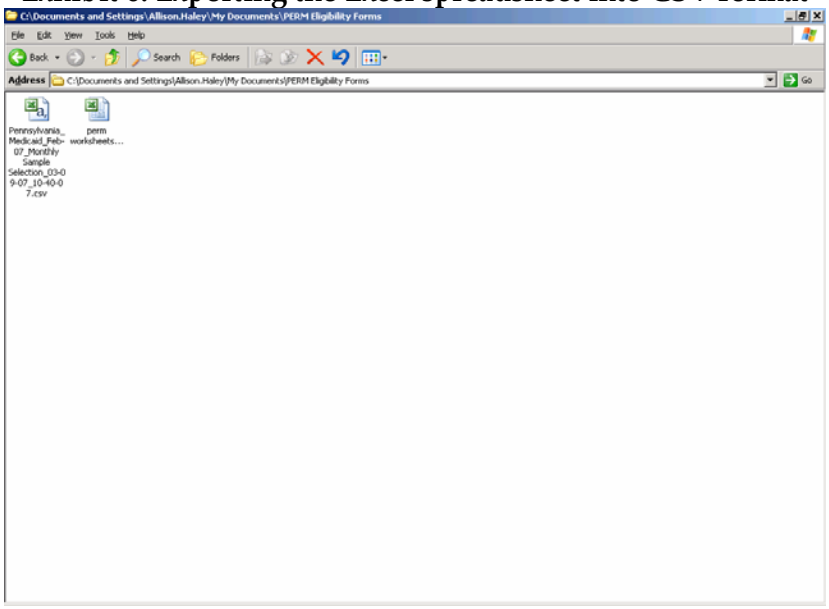
Once the data has been input into each form, States will have to run a macro to populate repeated fields in the other worksheets. See the instructions for each form for the specific combination of keys to press to automatically run the macro. To export and save the data in a file format for uploading, States will need to populate the form in Excel and save the file as an Excel spreadsheet in the location of your choice **(Exhibit 5)**. As a reminder, the same Excel workbook should be used throughout the eligibility review process for a given sample month.

Exhibit 5. Saving the Excel Spreadsheet



After saving the file, the State should run the macro for that worksheet (using the instructions in the next section). The Excel form will export the data to a CSV format in the same directory as the Excel file. The CSV file will have the State name, program, sample month, form name, date submitted, and time submitted in its title **(Exhibit 6)**. **Note:** Only the worksheet that is being populated will export into a CSV format.

Exhibit 6. Exporting the Excel spreadsheet into CSV format



Enabling Macros

The Excel workbook requires States to run a macro to convert the data into a format for uploading. Many States' IT networks will not automatically allow macros to run. States may need to adjust their computer security settings and "enable macros" in order for the spreadsheet to work correctly. Before exporting the forms to CSV, proceed with the following steps:

1. Open Excel.

2. Click on "Tools" and then "Options."

3. In the "Options" box, click on the "Security" tab.

4. Under the "Security" tab, click on the "Macro Security" button.

5. Change your macro security to "Medium." This will allow Excel to offer you the choice to enable the macro. The macros need to run only in the PERM eligibility reporting form document.

6. Open the PETT Excel file and click on the "Enable Macro" button **(Exhibit 7)**.

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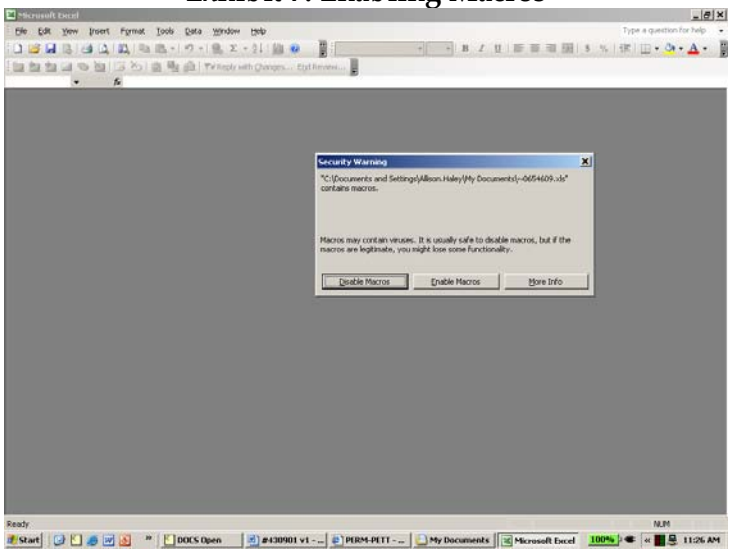
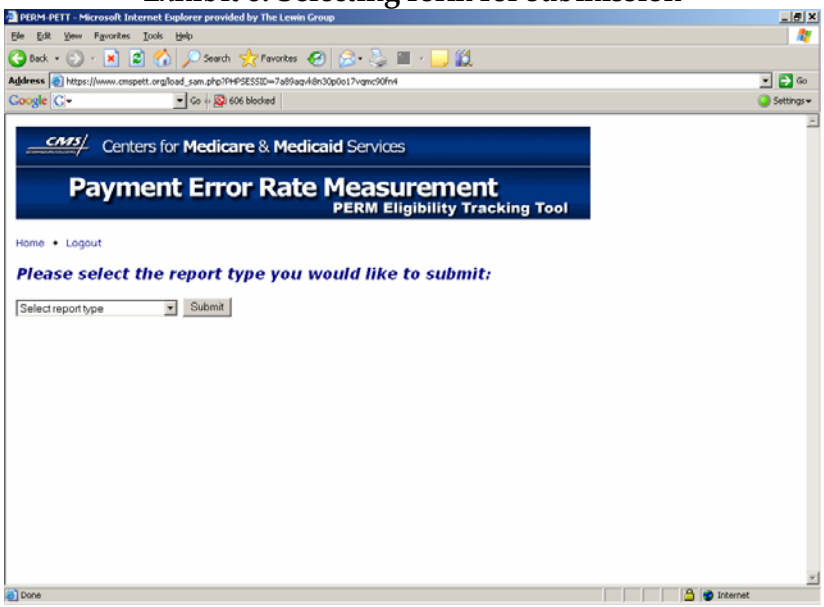
Exhibit 7. Enabling Macros



Instructions for Submitting Specific Forms

As noted above, four forms can be submitted using the PETT: the Monthly Sample Selection List, Detailed Review Findings for Active Case Reviews Report, Detailed Review Findings for Negative Case Reviews Report, and Detailed Payment Review Findings Report.

Exhibit 8. Selecting form for submission



Monthly Sample Selection List

To download and submit the Monthly Sample Selection List electronically:

1. After logging in, select the "Submit reports" link.

2. Using the drop down menu, States should select the form they will be submitting in order to proceed (Monthly Sample Selection List). (**Exhibit 8**)

3. Click the "Submit" button.

4. Click on the link at the top of the page to download the monthly report CSV form: "Click here to download the PERM Eligibility Tracking Tool spreadsheet forms."

5. When the Excel spreadsheet opens, click on the "Enable macros" button (Exhibit 4). The workbook containing the four forms will then open in Excel.

6. Save the file – you may want to rename with the State name and month (e.g., "NH March 07 PERM Eligibility Reporting Forms"). You will use the same file to populate the remaining three forms for this month.

7. Click on the tab for the Monthly Sample Selection List form.

8. Enter data into the form only in the outlined fields. If copying the data into the spreadsheet, please be sure that numbers are imported as numbers rather than text and that text is imported as text and not numbers. Also, please do not change any column headings or text. Failure to comply with these guidelines will prevent successful uploading of the reporting forms.

9. Once the data has been input into the form, States will be able to run a macro to populate repeated fields in the other worksheets. Press the "Control-Shift-G" keys simultaneously and the fields "Case/Beneficiary ID" will automatically populate in the remaining forms and the "Strata" field will populate in the Active Case Review Findings form as well as the Active Case Payment Findings form.

10. Once the data has been input into the form, the spreadsheet will need to be saved as a CSV file. First, save the file as an Excel spreadsheet in the location of your choice.

11. After saving the file, click on the tab for the Monthly Sample Selection List and press the "Control-Shift-L" keys simultaneously on your keyboard. After running the macro, the Excel form will export the data to a CSV format in the same directory as the Excel file. The CSV file will have the State name, program, sample month, form name, date submitted, and time submitted in its title. Upload the exported CSV file to the PETT website. **Note**: Only the worksheet that is being populated will export into a CSV format.

Detailed Review Findings for Active Case Reviews Form

To complete and submit the Detailed Review Findings for Active Case Reviews form:

1. After logging, in select the "Submit reports" link.

2. Using the drop down menu, States should select the form they will be submitting in order to proceed (Detailed Review Findings for Active Case Reviews form). (**Exhibit 8**)

3. Click the "Submit" button.

4. Open the Excel workbook for the relevant month from your computer.

5. When the Excel spreadsheet opens, click on the "Enable macros" button. The workbook containing the four forms will then open in Excel.

6. Click on the tab for the Active Case Review Findings form.

7. Enter data into the form only in the outlined fields. If copying the data into the spreadsheet, please be sure that numbers are imported as numbers rather than text and that text is imported as text and not numbers. Also, please do not change any column headings or text. Failure to comply with these guidelines will prevent successful uploading of the reporting forms.

8. Once the data has been input into the form, the fields "Dropped Due to Beneficiary Fraud" and "Review Finding" will automatically populate in the Active Case Payment Findings form.

9. Once the data has been input into the form, the Active Case Review Findings form will need to have the page breaks removed. This can be done by pressing the "Control-Shift-H" keys simultaneously.

10. Once the data has been input into the form and the line breaks have been removed, the spreadsheet will need to be saved as a CSV file. First, save the file as an Excel spreadsheet in the location of your choice. As a reminder, the same Excel workbook should be used throughout the eligibility review process for a given sample month.

11. After saving the document, click on the tab for the Detailed Review Findings for Active Case Review form and press the "Control-Shift-L" keys simultaneously on your keyboard. After running the macro, the Excel form will export the data to a CSV format in the same directory as the Excel file. The CSV file will have the State name, report name, sample month, date submitted and time submitted in its title. Upload the exported CSV file to the PETT website. **Note:** Only the worksheet that is being populated will export into a CSV format.

Detailed Review Findings for Negative Case Review Form

To complete and submit the Detailed Review Findings for Negative Case Review form:

1. After logging, in select the "Submit reports" link.

2. Using the drop down menu, States should select the form they will be submitting in order to proceed (Detailed Review Findings for Negative Case Reviews form). (**Exhibit 8**)

3. Click the "Submit" button.

4. Open the Excel workbook for the relevant month from your computer.

5. When the Excel spreadsheet opens, click on the "Enable macros" button. The workbook containing the four forms will then open in Excel.

6. Click on the tab for the Negative Case Review Findings form.

7. Enter data into the form. If copying the data into the spreadsheet, please be sure that numbers are imported as numbers rather than text and that text is imported as text

and not numbers. Also, please do not change any column headings or text. Failure to comply with these guidelines will prevent successful uploading of the reporting forms.

8. Once the data has been input into the form, the Negative Case Review Findings form will need to have the page breaks removed. This can be done by pressing the "Control-Shift-J" keys simultaneously.

9. Once the data has been input into the form and the line breaks have been removed, the spreadsheet will need to be saved as a CSV file. First, save the file as an Excel spreadsheet in the location of your choice. As a reminder, the same Excel workbook should be used throughout the eligibility review process for a given sample month.

10. After saving the document, click on the tab for the Detailed Review Findings for Negative Case Reviews and press the "Control-Shift-L" keys simultaneously on your keyboard. After running the macro, the Excel form will export the data to a CSV format in the same directory as the Excel file. The CSV file will have the State name, report name, sample month, date submitted and time submitted in its title. Upload the exported CSV file to the PETT website. **Note:** Only the worksheet that is being populated will export into a CSV format.

Active Case Payment Findings

To complete and submit the Active Case Payment Findings form:

1. After logging, in select the "Submit reports" link.

2. Using the drop down menu, States should select the form they will be submitting in order to proceed (Active Case Payment Findings). (**Exhibit 8**)

3. Click the "Submit" button.

4. Open the Excel workbook for the relevant month from your computer.

5. When the Excel spreadsheet opens, click on the "Enable macros" button. The workbook containing the four forms will then open in Excel.

6. Click on the tab for the Active Case Payment Findings form.

7. Enter data into the form. If copying the data into the spreadsheet, please be sure that numbers are imported as numbers rather than text and that text is imported as text and not numbers. Also, please do not change any column headings or text. Failure to comply with these guidelines will prevent successful uploading of the reporting forms.

8. Once the data has been input into the form, the Active Case Payment Findings form will need to have the page breaks removed. This can be done by pressing the "Control- Shift-K" keys simultaneously.

9. Once the data has been input into the form and the line breaks have been removed, the spreadsheet will need to be saved as a CSV file. First, save the file as an Excel spreadsheet in the location of your choice. As a reminder, the same Excel workbook should be used throughout the eligibility review process for a given sample month.

10. After saving the document, press the "Control-Shift-L" keys simultaneously on your keyboard. After running the macro, the Excel form will export the data to a CSV format in the same directory as the Excel file. The CSV file will have the State name, sample month, and date submitted in its title. Upload the exported CSV file to the PETT website. **Note:** Only the worksheet that is being populated will export into a CSV format.

Summary Findings and Error Rate Tables

The Summary Findings and Error Rate Tables will include a summary of findings as well as a reporting of your State program's error rate. In the future, there will be a mechanism added to the PETT website which will allow States to export the data already submitted into the summary form. States can then use the error rate calculator, which is currently under development, to calculate the State program's error rate. The Lewin Group will contact States when these features are available for use.