# Payment Error Rate Measurement (PERM)

*Eligibility Review Guidance for Medicaid and CHIP Benefits*

July 2011

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# Section 1 – Introduction

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

## 1.1 – Improper Payments Elimination and Recovery Act of 2010

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

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

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

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

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

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

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

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

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

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

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

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

## Section 2 – Eligibility Overview

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

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

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

The payment error rate for PERM is an annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample. The eligibility component, however, is more complex in that the results from the eligibility reviews will include eligibility errors based on erroneous decisions as well as payment errors that result from the eligibility errors (i.e., liability understated, liability overstated, eligible with ineligible services and managed care errors).

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

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

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

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

## Section 3 – Sampling Plan

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

Sampling plans generally should include the following information:

- State name
- Program (e.g., Medicaid or CHIP)
- Timeframe for sample (e.g., FY 2011)
- Name of independent agency responsible for PERM eligibility reviews
- Name, phone number, and email address of person responsible for answering questions relating to the sampling plan
- List of the agencies in the State that make eligibility determinations and a State agency contact responsible for overseeing eligibility appeals (if applicable)
- Whether or not the State has self-declaration policies and under what circumstances self-declaration is acceptable
- Description of MEQC activities for the current fiscal year
- Description of the eligibility systems from which the data is pulled
- Description of the active case universe and sampling process, including:
    - The data sources for the active case universe and how unique individuals or family units will be identified and included in the universe for sampling
    - Description and explanation (if necessary) of exclusions from the active case universe for Medicaid and CHIP, including how cases under beneficiary fraud will be addressed and that cases enrolled in Medicaid or CHIP using Express Lane Eligibility are excluded (if applicable)

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

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

## Section 4 – Sampling

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

Section 4 is divided into two parts. The first part describes the sampling process for active cases and the second part describes the sampling process for negative cases.

### 4.1 – Active Case Sample

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

#### 4.1.1 – Eligibility Sampling Unit

The PERM eligibility sampling unit is referred to as a "case" and is defined as an individual or family. (Note: A "family" may include just one beneficiary.) This parallels the definition of a case used in MEQC and will support PERM-MEQC harmonization as well as reflect current MEQC practice for States that sample at the application level. For States sampling at the individual beneficiary level, no changes to the State's existing PERM process are necessary. States that opt to sample at the family level will need to update their sampling plans accordingly.

States that sample at the individual beneficiary level will continue to report the total number of individual beneficiaries in the universe each month. States that opt to sample at the family level will report the total number of families in the universe each month.

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

### 4.1.2 – Identifying the Active Case Universe

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

Exclusions from the active case universe are:

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

All other 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 included in the active universe.

### 4.1.3 – Spend Down Cases

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

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

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

*Active without receiving benefits*: For States that capture spend down cases as active cases that are not receiving benefits states should include the case in the active universe for sampling and review according the guidelines presented in Section5 below. (Note: These cases would have no payment dollars collected as services received in the sample month were not matched with Title XIX dollars.)

### 4.1.4 – Sample Size for Active Cases

Sample sizes must be sufficient to meet the precision requirements that the estimate of the error rate be within 3 percentage points of the true error rate with a 95 percent level of confidence.

The base year sample size (i.e., the sample size to be used by States in their initial year conducting PERM eligibility reviews) was calculated under an initial assumption regarding the variance in the error rate. In the initial assumptions, the error rate was assumed to be 5 percent and the sample size sufficient to meet the precision requirements was calculated to 504 active cases.

After the base year, the State's sample size calculation will be based on the actual standard error associated with its more recent eligibility error rate estimate. If, in the State's more recent estimate, the precision requirements were exceeded, the sample size estimate will fall below 504. If, on the other hand, the State did not meet the precision requirement in its most recent estimate, sample sizes will increase above 504 cases. As a rule of thumb, if the State's eligibility payment error rate is below 5 percent, a smaller sample size may be sufficient to achieve the desired precision requirements. Similarly, States with eligibility payment error rates above 5 percent will generally be required to increase their sample size for the subsequent cycle. However, the actual sample size estimate will be based on the standard error of the most recently completed eligibility error rate, so that the rule of thumb may not apply in all instances. The statistical contractor will calculate sample sizes for subsequent years based upon the State's prior year eligibility error rate information. CMS has established a maximum sample size for eligibility at 1,000 active cases per program, regardless of a State's eligibility error rate in the prior cycle.

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

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

## 4.2 – Method for Drawing the Monthly Sample

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

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

- For simple random sampling, States should assign each case an integer from 1 to N, where N is the number of cases in the universe. Then, using a program that has a random number generator, such as Statistical Analysis Software (SAS), randomly generate enough integers in the range from 1 to N to meet the required sample size. For example, if the number of cases in the universe is 1,000, and a sample of 22 is needed, assign each case an integer from 1 to 1,000. The State would then generate 22 random integers between 1 and 1,000, without replacement. Cases that were assigned one of the randomly generated integers would be included in the sample.

- To use the "skip" factor method, divide the number of cases in the universe by the required sample size. This number becomes the "skip" interval or N. Using a program that has a random number generator, such as SAS, randomly select a number from 1 to N to be the starting point in the universe. Select that case and then every $N^{th}$ case until the required sample size is met. For example, if the number of cases in the universe is 1,000, and a sample size of 20 is needed, the skip interval would be 50. A random integer would be generated between 1 and 50 (inclusive of the end points). If this random number was 7, then, sample case number 7, case number 57, case number 107, etc. until the required 20 cases were drawn.
    - States may include oversample cases with the required cases when using the "skip" factor method. As discussed later in this section, States may want to draw an oversample to account for any problems that are discovered in the sample (active beneficiary fraud, etc.).
    - When using the "skip" factor method of sampling, the State has two options for selecting the oversample.
        1) The State may draw an initial sample that has a sufficient number of cases for the sample and oversample then randomly select the cases which will be considered the oversample cases. (Note: Taking the first two or last two cases as the oversample is not random.)
        2) Alternatively, the State may conduct a second systematic random sample to select the oversample but would first need to remove the cases that were initially sampled from the universe used to select the oversample.

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

**4.2.1 – Adjustments to the Monthly Sample**

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

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

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

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

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

## 4.3 – Negative Case Sample

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

### 4.3.1 – Identifying the Negative Case Universe

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

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, are excluded from the negative universe and should be placed in the active universe. Cases should only be included in the negative case universe if an application is denied or a case is terminated (e.g. a negative decision is made, the 10 day notice period has expired and the case is terminated from the programs).

### 4.3.2 – Sampling the Negative Case Universe

The universe for the negative case sample is determined each month and includes actions the State took to deny eligibility in the sample month or terminate eligibility based on the effective month of termination.

### 4.3.3 – Sample Size for Negative Cases

The base year sample size of 204 negative cases is required in order to obtain a precision level of 3 percentage points at the 95 percent confidence level for the negative case error rate. A State may request to apply the finite population correction to reduce its sample size (see Appendix E).

After the base year, if the State's negative case error rate is below 5 percent, a smaller sample size may be sufficient to achieve the desired precision requirements. Similarly, States with eligibility payment error rates above 5 percent will be required to increase their sample size for the subsequent cycle. The statistical contractor will calculate sample sizes for subsequent years based upon the State's prior year negative case error rate information. CMS has established a maximum sample size for eligibility at 1,000 negative cases per program, regardless of a State's eligibility error rate in the prior cycle.

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

## 4.4 – Method for Drawing the Monthly Sample

States will draw monthly samples from this universe of negative cases over the entire twelve months of the Federal fiscal year. The sample size should consist of 17 cases each month.

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. **See Section 4.2** for the methods for drawing a random sample.

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

### 4.4.1 – Substituting Negative Findings

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

## Section 5 – Eligibility Reviews of Active and Negative Cases

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

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

Please note that whether a State is sampling at the individual beneficiary or case level, eligibility determinations for each program associated with an individual must be reviewed for (e.g. a Qualified Individual with a spend-down case or a family where one individual is enrolled in more than one Medicaid category).

### 5.1 – Review Month

For PERM purposes, the review month is the month when the State's last action occurred and should be the month for which eligibility is verified.[2] There is no administrative period for the PERM eligibility reviews.[3]

The exception to verifying eligibility as of the review month is when the State's last action for a case occurred more than 12 months prior to the sample month. In that instance, eligibility for the case is verified as of the sample month.

**Example 1**: A case is sampled in January 2011. The State's last action occurred in May 2010. Eligibility for this case is verified as of May 2010 (the review month) because it occurred within the past 12 months.

**Example 2**: A case is sampled in January 2011. The State's last action occurred December 2009. Since the last action occurred more than 12 months prior to the sample month of January 2011, eligibility is verified for January 2011 (the review month).

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[2] For retroactive case, the review month is the month that the decision was made for retroactive coverage was made and could be a month after the sample month.

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

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

## 5.2 – Verification Standards

The purpose of the eligibility review is to verify the eligibility of sampled cases using State eligibility criteria in effect at the time of the decision under review (so long as the criteria comply with the approved State Plan and the State's written policy and procedures [e.g., State eligibility manual or State regulations], or if the State Plan or State policies are silent, Federal laws and regulations, including guidance in the State Medicaid Manual, State Health Official or State Medicaid Director letters). The guidance discussed below determines the extent to which the review obtains evidence relevant to the beneficiary's eligibility or ineligibility. CMS created this guidance to provide a systematic and nationally uniform method of verifying eligibility for PERM. However, these verification standards are not all inclusive. If the agency is unable to obtain documentation specified, eligibility can be verified through other reasonable evidence. Other reasonable evidence could include, but is not limited to: information from other beneficiary records, for example, the Supplemental Nutrition Assistance Program, third party sources, applicable caseworker notes, information obtained by the PERM reviewer over the telephone, and documentation listed in Section 7269 of the State Medicaid Manual.

### 5.2.1 – Required PERM Verification

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

### 5.2.2 – Acceptable Documentation

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

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

| Categorical Criteria Unlikely to Change | Financial Criteria Unlikely to Change | Categorical Criteria Likely to Change | Financial Criteria Likely to Change |
|---|---|---|---|
| Citizenship (in month eligibility is being verified) | Cash (resource[4]) | Residency | Bank Account (resource) |
| Social Security Number | House, other property (resource) | Household Composition (for income relationship purposes) | Earned Income-e.g. wages and salary |
| Death | Vehicle (resource) | | Unearned Income-e.g. RSDI, other government benefits, retirement income |
| Birth Date | Life Insurance (resource) | | |
| Pregnancy (in month eligibility is being verified) | Personal effects-e.g. boat, camper (resource) | | |

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

- Information on an application or redetermination form, including case worker notes from an interview;
- Documentation from a reliable third party source, e.g., employer wage statement showing earned income for the month eligibility is being verified;
- Caseworker notes in reasonable instances:
    - To verify residency: "Visit to Susie Jones at assisted living home. Ms. Jones is residing there."
    - To verify income: "Conducted a home visit and verified Bank of America statement for checking account #12345, dated March 2011, with an ending balance of $55.07 and no unusual deposits or withdrawals other than the Social Security benefit of $700";

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

- Copies of permanent documents (e.g., birth certificate, copy of Social Security card, regardless of when the document was obtained); and
- Information from other agencies or databases or electronic records as long as it does not conflict with Medicaid or CHIP case record information.

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

**5.2.3 – Acceptable Self Declaration**

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

Some States accept a signed statement for categorical and financial criteria as long as there is no Federal requirement to document the information, such as the Deficit Reduction Act of 2005 requirement to document citizenship for Medicaid. The Children's Health Insurance Program Reauthorization Act (CHIPRA) allows for States to verify citizenship for children enrolled in Medicaid and CHIP through the Social Security Administration (SSA).[5]

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

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

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

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

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

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

**5.2.4 – Simplified Enrollment and Passive Renewal for Applications and Redeterminations**

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

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

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

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

- Self-declared information qualifies as acceptable self-declaration for PERM.
- Documentation that originates from the last case action is still acceptable verification for PERM even if more than 12 months old.
- If State policy is that when a beneficiary does not return their renewal form and the beneficiary is thus self-declaring and attesting that his/her circumstances are the same as the previous year, this self-declaration is considered current and acceptable for PERM when case record documentation is more than 12 months old. Keep in mind that if State policy and procedure was followed and led to an automatic renewal in accordance with State policy, nothing new must be re-verified for PERM. However if a beneficiary returns their renewal form to report

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

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

## 5.3 – Process for Verifying Active Case Eligibility

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

**Step 1**: Determine the review month for the case. The review month is the month in which the last action was taken on a case, i.e., to grant or redetermine eligibility. Identify the date of the last State action taken on the case. If the last action was taken more than12 months before the sample month, verify eligibility as of the sample month (see exception for continuous eligibility policies in **Section 5.4.3).**

**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).

**Step 3:** 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; or
- Unacceptable under self-declaration guidelines.

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

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

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

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

- **Eligible**: A case meets the State's categorical and financial criteria for receipt of benefits under the program.
- **Not eligible:**[6] A case is receiving benefits under the program but does not meet the State's categorical and financial criteria being verified using the State's documented policies and procedures.
- **Eligible with ineligible services**: A case meets the State's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP program but was not eligible to receive particular services in accordance with the State's documented policies and procedures.
- **Undetermined**: The case record lacks or contains insufficient documentation, in accordance with the State's documented policies and procedures, to make a definitive review decision for eligibility or ineligibility.
- **Liability overstated**: The beneficiary overpaid toward an assigned liability amount or cost of institutional care and the State underpaid.
- **Liability understated**: The beneficiary underpaid toward an assigned liability amount or cost of institutional care and the State overpaid.
- **Managed care error 1**: Ineligible for managed care - Upon verification of residency and program eligibility, the beneficiary is enrolled in managed care but is not eligible for managed care.
- **Managed care error 2**: Eligible for managed care but improperly enrolled – The beneficiary is eligible for both the program and for managed care but not enrolled in the correct managed care plan as of the month eligibility is being verified.

If the agency cannot verify eligibility or confirm ineligibility, the following process must be followed prior to citing a 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

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

employers, the State should contact the beneficiary to obtain the needed information. The minimum efforts (all of which must be performed) required to contact the beneficiary are:

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

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

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

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

**Step 8**: Cases with findings of "Not Eligible" or with managed care errors or liability errors, should be forwarded to the State agency responsible for eligibility determinations so appropriate follow-up actions 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 State agency for a redetermination. Beneficiary participation in PERM is not a condition of Medicaid or CHIP eligibility and a beneficiary must not be terminated or sanctioned for not complying with requests for information from a PERM reviewer. Federal regulations do not provide for beneficiary penalties for not complying with Federal audits.

## 5.4 – Other Eligibility Review Situations

### 5.4.1 – Presumptive Eligibility

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

- Pregnant women;
- Women whose eligibility for Medicaid is based on needing treatment for breast or cervical cancer;
- Children; and

- People with disabilities being discharged from the hospital into the community (Section 6086 of the DRA that amends Section 1915 of the Social Security Act).

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

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

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

### 5.4.2 – 100 Percent Federally Funded Cases

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

### 5.4.3 – Continuous Eligibility

Continuous eligibility is when coverage is extended to a child at the time of application or redetermination for a predetermined period specified in the State plan (no longer than 12 months) without regard to changes in income or any other changes in circumstances (except death, move to a different State, or attaining the age limit for continuous eligibility specified in the State plans, requests disenrollment or, if on CHIP, becomes eligible for Medicaid) as provided by Section 1902(e)(12) of the Act or applicable CHIP regulations.

To review cases in continuous eligibility status for PERM, verify eligibility as of the date the State took the action to grant continuous eligibility based on an application or redetermination. Eligibility can be verified through documentation in the case record, or a new self-declaration statement. If a new self-declaration statement cannot be obtained, or is inconsistent with facts in the case record, other reasonable evidence can be used to complete the review.

### 5.4.4 – CMS-Approved Waivers

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

- Natural disasters/States of Emergency

- Continuous Eligibility
- Delayed Redeterminations
- Presumptive Eligibility

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

### 5.4.5 - SSI Conversion Cases

For SSI conversion cases, Federal regulations at 42 CFR §435.1003 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.

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

### 5.4.6 – Spend Down Cases

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

## 5.5– PERM Technical Errors

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

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

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

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

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

## 5.6 – Process for Conducting Medicaid and CHIP Negative Case Reviews

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

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

**Step 2**: Examine the evidence in the case file to verify whether the State's reason for denial or termination was correct. For example, if the case was denied due to excess income, review the income verification in the case file to determine whether it exceeded State income levels. For details on what constitutes sufficient evidence in the case record, please see Section **5.2.2, Acceptable Documentation** or Section 7269 of the State Medicaid Manual.

**Step 3**: Use one of the following eligibility codes that best fit the main circumstance for any negative case finding:

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

**Step 4**: If the reason for the beneficiary's denial or termination of benefits was correct, cite the case **Correct**. If the reason for the beneficiary's denial or termination of benefits was incorrect, determine whether the evidence in the case record supports the negative action for any other reason.

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

Cite the case **Improper Denial** or **Improper Termination** if no evidence exists to support the denial or termination.

**Step 5**: Determine if an improper denial or termination could be eligible for another category. Refer improper denial and termination case findings to the State agency responsible for eligibility determinations so appropriate action on an individual case can be taken. The State may evaluate the beneficiary's possible program reinstatement.

**Step 6:** The State may employ its eligibility appeals process (if applicable).

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

## Section 6 – Payment Reviews of Active Medicaid and CHIP Cases

Payment reviews must be conducted to determine the active case payment error rate, which is a dollar-weighted error rate. States must identify the claims and managed care payments associated with the cases in the monthly sample. The dollar values of the payments associated with all sampled cases (including eligible cases and cases with eligibility errors) will form the basis of the dollar-weighted error rate. Note that States should not conduct a review of the actual payments (e.g., for medical necessity or coding). Rather, States should determine if the beneficiary's eligibility entitled them to the received services.

States must wait five months following the sample month before identifying claims. Claims are identified and associated with a case in accordance with the State's policy on effective date of eligibility. For example, most States provide "full month" coverage in that, if a beneficiary is eligible at any point during the month then the beneficiary's eligibility is effective as of the first day of the month. Other States have "date-specific" eligibility in that eligibility is effective on the date of the Medicaid application or, with CHIP, can be made effective prospectively. The example below (Exhibit 6-1) illustrates the timeframe for identifying a payment for a case sampled in October. Because the service was received in October (the sample month) and paid within the four-month timeframe, the payment would be included for PERM. Additionally, because the adjustment to the payment was made in April (within the subsequent 60 days), the total dollars collected for the sampled case would reflect the adjusted amount for the service received in October.

**Exhibit 6-1: Example of Timeframe to Collect October Payments**

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

### 6.1 – Instructions for Conducting Medicaid and CHIP Payment Reviews

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

**Step 1:** Identify services received in the sample month.

**Step 2**: Identify claims and capitation payments for services received within the sample month or first 30 days of eligibility. Tally the payment amounts for services received in the sample month or first 30 days of eligibility and the subsequent 4 months, as applicable. The agency may also wait an additional 60 days after the paid dates to apply adjustments.

**Step 3**: Verify whether the payments were made appropriately based on the eligibility review findings. The payment review may include determining the beneficiary met his/her liability amount or cost of

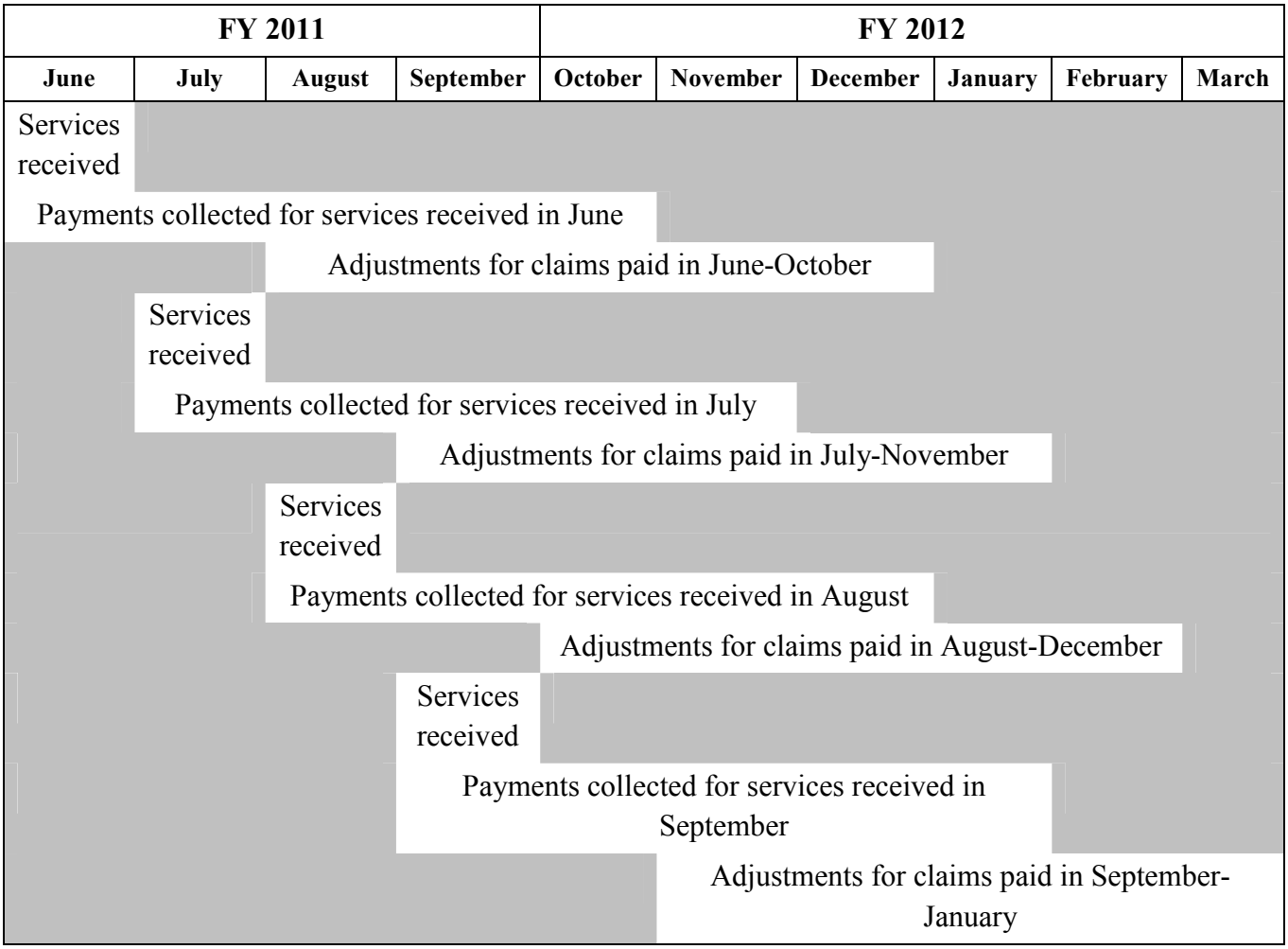
institutional care, and could result in a **Liability Overstated** or **Liability Understated** error depending on whether the beneficiary paid too little or too much towards cost of care. The payment review should also determine whether the beneficiary as eligible for the services received. Payments for services for which the beneficiary is not eligible to receive are considered improper and are included in the error rate calculation.

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

**Step 5**: For **Undetermined** cases where eligibility could not be verified, identify and tally the claims for the services received in the sample month or first 30 days of eligibility as appropriate, and record the amount for each Undetermined case. Payments identified for cases found to be Undetermined must be reported.

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

**Exhibit 6-2: Five Month Payment Collection Falling Outside the Fiscal Year**




## 6.2 – Other Payment Review Situations

### 6.2.1 – Managed care capitation payments

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, if sampling the individual and not the family, 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 are included in the review regardless of the actual payment date, so long as the payment dates fall within the five month

timeframe. In some States, managed care payments are made to Managed Care Organizations (MCOs) in the month before the month of coverage. Prospective payments for the sample month will be counted.

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

In some States, beneficiaries are enrolled in managed care, but may also receive services on a fee-for-service basis in which claims are paid in addition to the managed care capitation payment. In these instances, all payments, managed care, fee-for-service or both must be included in the eligibility payment review.

### 6.2.2 – Beneficiary premiums

In some States beneficiaries pay a premium for Medicaid or CHIP coverage to the State, which is then combined with State and Federal funds to pay a managed care organization that provides the coverage. The payment review for these cases should consider whether or not the beneficiary's premium payment was calculated correctly to determine whether or not there is a payment error. The payment amounts reported should not include the premium amount, but the amount paid with State and Federal dollars.

Also, in the review month or sample month, there may be some instances where a sampled case did not pay the necessary premium in that month. For Medicaid, States allow beneficiaries a 60 day grace period towards unpaid premiums before terminating eligibility or suspending coverage (§1916(c)(3) of the Act). For CHIP, States must notify beneficiaries within a certain number of days to pay all premiums in full either before an upcoming redetermination or before terminating eligibility or suspending coverage (42 CFR §457.505(c) and §457.570). If the monthly premium is not paid by the beneficiary in the review month or sample month, review your State plan to determine the time period in which premiums must be paid or penalties for nonpayment of the premium. These would be the basis for improper payments, if any.

## Section 7 – Eligibility Appeals

As stated in the PERM regulations at §431.974(a)(2), personnel responsible for PERM eligibility sampling and review "must be functionally and physically separate from the State agencies and personnel that are responsible for Medicaid and CHIP policy and operations, including eligibility determinations." The intent of this provision was to ensure the independence of the review in order to achieve an unbiased error rate. We provided further clarification in the preamble of the August 2007 final rule, indicating that the agency responsible for PERM could be under the same umbrella agency that oversees policy, operations and determinations but the two agencies cannot report to the same supervisor.

In the preamble to the proposed rule published in July 2009, we further clarified that qualified staff with knowledge of State eligibility policies may be used to conduct the eligibility reviews, but the staff that is chosen must be independent from the staff that oversees policy and operations. We would further like to clarify that we consider staff to be independent if they temporarily work on PERM eligibility reviews even though they usually work under eligibility policy and operations, so long as the staff does not discuss PERM eligibility reviews with the staff that oversees policy and operations during the time the staff is working on PERM eligibility reviews. Furthermore, we ask in the PERM eligibility instructions to provide assurance that the agency or contracting entity responsible for the PERM eligibility reviews ("Agency") is independent of the State Medicaid or CHIP agency responsible for eligibility determination and enrollment. The State is responsible for ensuring the integrity of the PERM eligibility reviews, but we do not preclude the agency from sharing or reporting the PERM eligibility review findings to the State Medicaid or CHIP agencies.

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

The State Medicaid or CHIP agencies may document their differences in writing to the agency for consideration. If resolutions of differences occur during the PERM cycle, eligibility findings can be updated to reflect the resolution. If differences are not resolved by the deadline for eligibility findings to be submitted to CMS (July 1), the documentation of the difference can be submitted to CMS for consideration no sooner than 60 days and no later than 90 days after the deadline for eligibility findings.

In consideration of States that may not have a State appeals process in place, CMS will allow the Agency to make State findings available to each respective State's Medicaid and CHIP agencies for the period between the final monthly payment findings submission and eligibility error rate calculation, for example, April 15th through June 15th after the fiscal year being measured or according to the eligibility timeline. CMS will facilitate documentation exchange between the State Medicaid or CHIP agency and the agency conducting the PERM eligibility reviews to resolve differences.

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

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

## Section 8 – Reporting

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

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

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

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

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

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

template for October, one for November, etc.). For States that choose to input the data directly into the form, submitted data will be available for review. States that input data directly on the website will also be able to download copies of submitted data for their own records.

Sample forms for PERM are in Appendix I.

## Section 9 – Calculating Medicaid and CHIP Eligibility Error Rates

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

For active cases, the following error rates are calculated:

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

For negative cases:

- A case error rate.

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

- Undetermined included as payment errors; and
- Undetermined excluded as payment errors.

## Section 10 – PERM Corrective Action Plan (CAP)

Following each measurement cycle, the States included in the measurement are required to complete and submit a Corrective Action Plan based on the errors found during the PERM process. CMS provides guidance to State contacts on the CAP process.

The CAP process involves analyzing findings from the PERM measurement, identifying root causes of errors and developing corrective actions designed to reduce major error causes, trends in errors or other vulnerabilities for purposes of reducing improper payments. Through the CAP process, States are able take administrative actions to reduce errors which cause improper Medicaid and CHIP payments.

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

# Appendix A: PERM Eligibility Medicaid and CHIP Timeline

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

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

## Appendix B: Glossary

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

**Active fraud investigation**: A beneficiary or a provider has been referred to the State Medicaid Fraud Control Unit or similar Federal or State investigative entity including a Federal oversight agency and the unit is currently actively pursuing an investigation to determine whether the beneficiary or the provider committed health care fraud.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Payment**: Any payment to a provider, insurer, or managed care organization for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP Federal financial participation. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulations or policy.

**Payment Error Rate**: An annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

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

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

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

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

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

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

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

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

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

## Appendix C: Sampling Plan Template Outline

| Eligibility Sampling Plan for [State]<br>Program: [Medicaid or CHIP]<br>Fiscal Year [Year]<br>Independent Entity [Agency] |
|---|
| **Agency Independence:**<br><br>The State should identify the agency and personnel or contracting entity responsible for eligibility reviews in its sampling plan with a stated assurance that the agency is independent of the State agency responsible for policies, operations and eligibility determinations and enrollment or that the contracting entity is independent of the State's eligibility and enrollment activities. Please indicate any of the following circumstances that are applicable to your State:<br><br>(1) That the agency responsible for PERM is under the same umbrella agency that oversees policy, operations and determinations but the two agencies do not report to the same supervisor;<br><br>(2) That qualified staff with knowledge of State eligibility policies is used to conduct the eligibility reviews, but the staff that is chosen is independent from the staff that oversees policy and operations; or<br><br>(3) The staff is considered to be independent because they temporarily work on PERM eligibility reviews even though they usually work under eligibility policy and operations, and that staff is barred from discussing PERM eligibility reviews with the staff that oversees policy and operations during the time the staff is working on PERM eligibility reviews. |
| **State Medicaid and/or CHIP agency:**<br><br>List and describe the agencies in the State that make eligibility determinations. Note that this may also be information that the Agency may want to record during the review process for corrective action purposes.<br><br>**Eligibility Appeals Contacts**:<br><br>List the contact information for State Medicaid and CHIP personnel that will be involved in State-level eligibility appeals. If no appeals process exists at the State level, these will serve as contacts for CMS to facilitate documentation exchange between the Agency and State Medicaid and CHIP agency. |

**Self-Declaration States:**

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

**Description of MEQC Activities for the Current Fiscal Year**

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

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

**Data Systems**

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

**Active Cases**

1. Description of the Universe for active cases.

2. Indicate if the State has implemented Express Lane Eligibility and an estimate of the number of beneficiaries enrolled using Express Lane Eligibility as of the date of the sampling plan.

3. Description of the strata for active cases (if applicable).

4. Description of the following:

- How the monthly sample will be drawn;
- How cases will be selected including the method used to randomly select cases;
- The number of cases that will be oversampled to account for fraud cases or other cases inappropriately included in the sample.

5. The quality control procedures that will be applied including procedures to ensure completeness of the population from which the sample is drawn.

6. Description of how records or claims and managed care payments associated with the cases sampled will be obtained.

| |
|---|
| 7. Projected monthly sample size for each stratum (if applicable). |
| 8. A description, and underlying assumptions, regarding how the sample size was determined. If the sample size deviates from that recommended in this instruction due to the application of a finite population correction (i.e., the State's universe for the previous fiscal year is less than 10,000), a detailed explanation is required of how the alternative sample size was estimated and why it is likely to achieve precision requirements. Sample sizes that are less than the recommended sample size must be approved by CMS, i.e., finite population, prior to implementation. If the sample size (whether it increases or decreases) is based on the eligibility payment error rate from the previous PERM cycle, indicate that here. |
| **Negative Cases**<br><br>1. Description of the universe for negative cases. |
| 2. Description of how the monthly sample will be drawn, the random method used to select cases, and the quality control procedures that will be applied. |
| 3. Projected monthly sample size |
| 4. A description, and underlying assumptions, regarding how the sample size was determined. If the sample size deviates from that recommended in this instruction due to the finite population correction, a detailed explanation of how the alternative sample size was estimated and why it is likely to achieve precision requirements is required. Sample sizes that are less than the recommended sample size due to the finite population correction (i.e., the State's universe for the previous fiscal year is less than 10,000) must be approved by CMS, based on the information in the sampling plan, prior to implementation. If the sample size (whether it increases or decreases) is based on the eligibility payment error rate from the previous PERM cycle, indicate that here. |

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# Appendix D: PERM Eligibility Stratification

## Stratification Overview

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

## Stratification Sampling

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

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

## Stratification Assignment

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

- **Stratum one (new applications)**: A case should be placed in stratum one in either the month that the State took an action to grant eligibility or in the month that a newly approved application becomes effective, whichever is later.
    - **Note**: States should count an individual reapplying for Medicaid or CHIP after a break in eligibility as a new application and place the case in stratum one.
- **Stratum two (redeterminations)**: A case should be placed in stratum two in either the month that the State took an action to continue eligibility or in the month that a new eligibility period begins, whichever is later.
- **Stratum three (all other cases)**: All other cases (properly included in the universe but do not meet the strata one or two criteria) that are on the program in the sample month are placed in stratum three.

Assigning active cases to either stratum one – new applications or stratum two – redeterminations should be based on the decision month or the effective month, whichever is later. The decision month is the month when a State makes a decision to grant or continue eligibility to a beneficiary after an

application or redetermination is complete. The effective month is the month when the beneficiary becomes eligible to receive Medicaid or CHIP services. States should **not** include a case in stratum one or stratum two in any month prior to when the decision to grant or continue eligibility was made (see examples below). Cases in stratum three should be sampled for each month in which the beneficiary is receiving Medicaid or CHIP coverage and is not a new application or redetermination in that month.

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

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

- **Continuous eligibility cases**: After the being included in stratum one in the initial month that eligibility becomes effective or the decision to grant eligibility is made (whichever is later), these cases should be in the stratum three universe for the remainder of the continuous eligibility period; include continuous cases in stratum two in the month the 12-month redetermination becomes effective.
- **September sample**: States should only include cases in their September universe for stratum one and stratum two cases that have an effective date in September; Cases approved or redetermined for coverage in September for eligibility beginning in October should **not** be included in the September sampling universe.
    - Example: A State decides on September 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.
- **SSI conversion cases**: The State should place SSI conversion cases in Stratum 3 until the State redetermines eligibility and should place SSI conversion cases in Stratum 2 in the month when the redetermination becomes effective.

- If these cases are found to be ineligible for continued Medicaid coverage, they should go into the negative universe in the month the decision was made to terminate unless the case is being continued pending the 10-day advance notice or until an appeal is finalized.
- States should note that, for SSI conversion cases, Federal regulations at 42 CFR 435.1003 limits Federal financial participation to the end of the month in which SSA notifies the State of the loss of SSI (if received before the 10th of the month) or until the end of the next month (if notification is received after the 10th of the month) and requires a "prompt redetermination of eligibility".

**Spend Down**

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

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

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

*Active without receiving benefits*: For States that capture spend down cases as active cases that are not receiving benefits, states should review include the case in the active universe for sampling and review according the guidelines presented in Section5 below. (Note: These cases would have no payment dollars collected as services received in the sample month were not matched with Title XIX dollars.)

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

**Retroactive Eligibility**

Retroactive eligibility is when an applicant is eligible for Medicaid in any or all of the three months prior to the month of application (e.g., an applicant applies in April where the eligibility is effective beginning in January). Whether a State grants date-specific eligibility or full month eligibility the three month retroactive period should not be considered for sampling purposes and is not included for eligibility review or payment collection review purposes. See the chart below that illustrates why the 3-month retroactive period in Medicaid would not fall into the universe of cases for the April sample month.

**Retroactive Cases Not Included in Universe**

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

## Review of Stratified Cases

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

- For stratum one cases, the review month is the month in which a decision was made to grant eligibility.

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

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

**Payment Collection for Stratified Cases**

For cases in strata 1 and 2, the agency will identify payments for services received in the sample month or the first 30 days of eligibility, depending upon whether the State grants full month or date specific eligibility. Payments for cases in stratum three are identified as of the sample month. Only include payments for services received in the sample month or the first 30 days of eligibility (if applicable) and paid in that month and in the four 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. States should follow all other payment guidelines, as provided in **Section 6**.

**Other Payment Collection Situations**

**Managed care capitation payments:**

All managed care payments made for coverage in the review month for Strata 1 and 2 cases or in the sample month for Stratum 3 are included regardless of the actual payment date so long as the payment dates fall within the five month timeframe. In some States, managed care payments are made to managed care organizations in the month before the month of coverage. Prospective payments for the sample month will be included.

## Appendix E: Active and Negative Case Eligibility Sample Size

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

*Eligibility Sample Size Calculation*

The error rate estimate is given by

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

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

$P$ = total payments

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

For the eligibility category,

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

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

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

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

$\pi_i$ = chance an observation in the $i$-th stratum is "in error".

Then, the error rate can alternatively be written as,

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

The variance of is given by,

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

Assume,

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

Now,

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

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

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

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

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

Then,

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

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

By Neyman-Pearson optimal allocation,

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

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

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

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

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

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

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

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

The margin of error, *d*, is thus

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For a simple random sample,

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

($\pi$ 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 $\mu_P$ is, $\hat{\mu}_P = \overline{P}$.

Hence, for a simple random sample

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

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

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

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

~ $\alpha$ = 0.05

~ $d$ = 0.03 (3.0 percentage points)

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

***Finite Population Correction Factor***

**Formula to determine sample size based on FPC**

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

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

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

Formula to determine sample size to meet required confidence and precision

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

and

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

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

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

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

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

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

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

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

| Provision | "Traditional" MEQC | PERM |
|---|---|---|
| **Incomplete Reviews** | **Cases can be dropped from review if:**<br>• Client cannot be located;<br>• Client does not respond to requests for information; or<br>• Client has moved out of State. | Information not retrieved for the PERM review could result in an "Undetermined" finding. |
| **Precision** | 95% confidence with +/- 2% precision | 95% confidence with +/- 3% precision |
| **Recovery of Improper Payments** | Disallowance provision apply for States with improper payments over the 3% National Standard. | Recoveries for Medicaid and CHIP for improper payments found in Fee for Service and Managed Care. Disallowance provisions of Section 1903(u) of the Act for Medicaid eligibility improper payments. Disallowance provisions under Section 2105(e) of the Act apply for CHIP eligibility improper payments. |
| **Review Month** | Review month and sample month are the same. | Review month is the date of last action on a case, up to 12 months prior to sample month. Review month is sample month if last action was more than 12 months prior to sample month. |
| **Sample Size** | Varies by State: Minimum sample sizes for each State in MEQC manual. | Base year sample size is 504 active cases. Can be reduced in future cycles using prior year(s) data. Can also increase if State-specific eligibility error rate is more than 5 percent. |
| **Sampling Unit** | Assistance unit; Family unit; "case" | Individual beneficiary or family. |

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

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

## Appendix G: PERM-MEQC Data Substitution

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

**Develop a Sampling Plan**

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

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

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

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

***Stratum 1: Applications***—the State took action to grant eligibility in the month or a newly approved application becomes effective, whichever date is later.

***Stratum 2: Redeterminations***—the State took action to continue eligibility in the month or a new eligibility period begins, whichever is later.

***Stratum 3: All Other Cases***—Cases that are on the program in the month, but have not had an application or redetermination.

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

**Review Requirements**

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

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

**Substituting MEQC reviews**

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

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

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

**Modified MEQC Review Requirements**

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

The Modified MEQC review includes:

1. **Case Record Review**

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

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

**2. Field Investigation**

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

**3. Assign Error Findings**

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

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

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

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

**Substituting PERM Reviews**

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

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

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

same. A State does not have to substitute active case data to use this option. Please see the Eligibility Review Guidance at **Section 4.2-Negative Case Sample.**

## PERM & MEQC Payment Reviews

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

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

### PERM Payment Review Process Example

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

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

## Error Rate Calculation

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

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

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

**Administrative Funding**

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

**Reporting**

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

# Appendix H: Calculating Medicaid and CHIP Eligibility Error Rates

## Calculating the Active Case Payment Error Rates

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

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

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

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

Where

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

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

$m_k$ is the number of cases sampled from stratum k,

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

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

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

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

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

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

And

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

where

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

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

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

Then,

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

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

Then, estimated variance is given by

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

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

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

**Calculating Active and Negative Case Error Rates**

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

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

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

Where

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

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

$m_k$ is the number of cases sampled from stratum $k$;

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

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

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

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

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

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

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

Where

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

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

*m* is the sample size.

The sampling variance of this estimator is

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

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

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

## Appendix I: Reporting Forms

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

| | |
|---|---|
| **A: State** | |
| **B: Date** | |
| **C: Program** | |
| **D: Sample Month** | |
| **E: Active Universe Total** | |
| **E1: Stratum 1 Universe Total (if applicable)** | |
| **E2: Stratum 2 Universe Total (if applicable)** | |
| **E3: Stratum 3 Universe Total (if applicable)** | |
| **F: Negative Universe Total** | |

| **Case/ Beneficiary ID** | **Eligibility Category** | **Universe** | **Stratum (if applicable)** | **Case Action** | **Review Month** | **Review Finding** | **Total Dollars** | **Total Dollars in Error** | **Total Dollars Correct** | **Total Dollars Undetermined** | **Cause of Error** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| 3. | | | | | | | | | | | |
| 4. | | | | | | | | | | | |
| 5. | | | | | | | | | | | |

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

# INSTRUCTIONS FOR COMPLETING THE PERM ELIGIBILITY REVIEWS
# PERM ELIGIBILITY REVIEW FINDINGS

**Purpose**: These instructions provide guidance on completing the eligibility review findings form. The eligibility review findings form provides the base level information about the cases that have been randomly selected for each sample month. States submit one eligibility review findings form 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.

The eligibility review findings form has multiple due dates. Each date that the form is due, more information is entered to complete the form. Please see the eligibility timeline in Appendix A of the eligibility review guidance for specific due dates.

- The monthly sample selection is due to CMS on the 15th day of the month after the sample month and must be submitted before eligibility reviews begin.
- The eligibility review findings for active and negative case reviews are due at the end of the month, five months after the sample month.
- The payment review findings for active cases are due on the 15th day of the month, 7 months after the sample 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 each submission is being submitted to CMS (e.g., February 15th, 2011)

**Line C: Program**
Enter the program for which the Eligibility Review Findings form applies (e.g., Medicaid or CHIP)

**Line D: Sample Month**
Enter the month and year for which the sample was drawn from the universe, e.g., January 2011. "Universe" refers to the total number of cases in the sample month. The universe will be unique for each month.

**Line E: Active Universe Total**
Enter the total number of active 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. (Note: If stratifying, complete lines E1 – E3, reporting the universe totals for each stratum).

**Line F: Negative Universe Total**
Enter the total number of negative cases in the universe during the sample month. The negative universe is the total number of cases that have either been denied or terminated from the program in the sample month.

**Case/Beneficiary ID:** "Case" refers to an individual beneficiary or family and could be the considered a household. In this column, enter the case identification (ID) or beneficiary ID, whichever is the custom of the State that correlates with the case reported as sampled on the monthly sample selection for the sample month. This column should include the ID numbers for active and negative cases.

**Eligibility Category:** Enter the category of assistance in which the case is enrolled or the category of assistance in which the case is denied or terminated, e.g., Qualified Medicare Beneficiary (QMB). If a denied case is not considered under any category, enter **Unknown** into this column. Please do not use State-specific abbreviations and use the best description of the eligibility category as possible.

**Universe:** Enter **Active** in this column if the sampled case is drawn from the active universe.
Enter **Negative** in this column if the sampled case is drawn from the negative universe.

**Stratum:** Enter the number of the eligibility stratum for each sampled case (i.e., 1, 2 or 3). The strata are as follows:

- Stratum 1—Applications: A case constitutes an application for the sample month if the State took an action to grant eligibility in that month based on a completed application.
- Stratum 2—Redeterminations: A case constitutes a redetermination for the 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 1 or 2 criteria) that are on the program in the sample month are placed in stratum 3.

The Stratum column should only be used by States that opted to stratify their cases into the three eligibility strata by last case action**. If the State did not stratify the cases, this column must be left blank.**

**Case Action:** Identify the last case action on the case.

Enter **Application** in this column if the action on the case was to grant eligibility based on a completed application.

Enter **Redetermination** in this column if the action on the case was to redetermine eligibility based on a completed redetermination.

The Case Action column should only be used by States that opted not to stratify their cases into the three eligibility strata by last case action.

**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 when the State's last action occurred. If the last action occurred more than 12 months prior to the sample month, then eligibility is reviewed as of the sample month. Enter the month in which eligibility is reviewed, either the review month or the sample month, as appropriate.

**Review Finding:** Enter the code for the review finding for each case. The review findings are as follows:

- **E**: Eligible--A case meets the State's categorical and financial criteria for receipt of benefits under the program.
- **NE**: Not eligible--An individual beneficiary or family is receiving benefits under the program but does not meet the State's categorical and financial criteria being verified using the State's documented policy and procedures.
- **EI**: Eligible with ineligible services--An individual beneficiary or family meets the State's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP program but was not eligible to receive particular services in accordance with the State's documented policies and procedures.
- **U**: Undetermined--The case record lacks or contains insufficient documentation, in accordance with the State's documented policies and procedures, to make a definitive review decision for eligibility or ineligibility.
- **L/O**: Liability overstated--The beneficiary overpaid toward an assigned liability amount or cost of institutional care and the State underpaid.
- **L/U**: Liability understated--The beneficiary underpaid toward an assigned liability amount or cost of institutional care and the State overpaid.
- **MCE1**: Managed care error 1--Ineligible for managed care - Upon verification of residency and program eligibility, the beneficiary is enrolled in managed care but is not eligible for managed care.
- **MCE2**: Managed care error 2--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.
- **C**: Correct--The negative case was properly denied or terminated by the State.

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

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

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

**Total Dollars:** Enter the total dollars of claims paid for services received in the sample month by each case.

**Total Dollars in Error:** Enter the amount of payment that is in error based on each case's:

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

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

**Payment Amount Correct:** A correct payment amount is a payment to a provider, insurer or managed care organization based on the case's eligibility for the program and for the services received under the coverage group under which the case is eligible as defined in the State's plan.

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

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

Place a zero in this column if there are not correct payment amounts.

**Total Dollars Undetermined:** Enter the amount of payments that are undetermined based on a case not having the verification necessary to make an eligibility review decision. The total payment amount for an undetermined case must be placed in this column. Place a zero in this column if the case is not undetermined.

Leave payment columns blank if a case is dropped.

**Cause of Error:** Enter the cause of the error for cases that are not eligible or have a payment error. 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.

## Payment Error Rate Measurement (PERM) Eligibility Reviews
## Summary Findings

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

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

Signature: _____ Date: _____

State Medicaid or CHIP Director or Designee

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

# INSTRUCTIONS FOR COMPLETING THE PERM ELIGIBILITY REVIEWS SUMMARY FINDINGS

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

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

## Line By Line Instructions

### SUMMARY FINDINGS TABLE

**Line A: State**

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

**Line B: Date**

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

**Line C: Program**

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

**Line D: Active**

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

**Line E: Negative**

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

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

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

Enter the total number of denials sampled for the year.

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

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

**Line F: Totals**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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