Payment Error Rate Measurement Manual

Version 1.0

Updated December 22, 2010

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10.1 - Overview of the Payment Error Rate Measurement Program

The purpose of the Payment Error Rate Measurement (PERM) program is to produce a national-level error rate for Medicaid and the Children's Health Insurance Program (CHIP) in order to comply with the requirements of the Improper Payments Information Act of 2002.

10.2 - PERM Legislative Background

The Improper Payments Information Act of 2002 (IPIA), Pub. L. 107–300, enacted on November 26, 2002, requires the heads of Federal agencies annually to review programs they oversee that are susceptible to significant erroneous payments, to estimate the amount of improper payments, to report those estimates to the Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures. The IPIA directed the Office of Management and Budget (OMB) to provide guidance on implementation. OMB defines "significant erroneous payments" as annual erroneous payments in the program exceeding both 2.5 percent of program payments and $10 million (OMB M–03–13, May 21, 2003 and OMB M–06–23, August 10, 2006). For those programs with significant erroneous payments, Federal agencies must provide the estimated amount of improper payments and report on what actions the Agency is taking to reduce them, including setting targets for future erroneous payment levels and a timeline by which the targets will be reached.

According to the OMB directive, Federal agencies must include in the report to the President and Congress: (1) the estimate of the annual amount of erroneous payments; (2) a discussion of the causes of the errors and actions taken to correct those problems, including plans to increase agency accountability; (3) a discussion of the amount of actual erroneous payments the agency expects to recover; (4) limitations that prevent the agency from reducing the erroneous payment levels, that is, resources or legal barriers; and (5) a target for the program's future payment rate, if applicable.

The Medicaid program and CHIP were identified by OMB as programs at risk for significant erroneous payments. OMB directed the Department of Health and Human Services (DHHS) to report the estimated error rates for the Medicaid and CHIP programs each year for inclusion in the Performance and Accountability Report (PAR). Through the Payment Accuracy Measurement (PAM) and Payment Error Rate Measurement (PERM) pilot projects that CMS operated in Fiscal Years (FYs) 2002 through 2005, we developed a claims-based review methodology designed to estimate State-specific payment error rates for all adjudicated claims within 3 percent of the true population error rate with 95 percent confidence. An "adjudicated claim" is a claim for which either money was obligated to pay the claim (paid claims) or for which a decision was made to deny the claim (denied claims).

The IPIA was amended on July 10, 2010 by the enactment of the Improper Payments Elimination and Recovery Act (IPERA), Pub. L. 111-204. IPERA requires agencies to

conduct annual risk assessments, and if a program is found to be susceptible to significant improper payments, agencies must measure improper payments in that program.

10.3 - CMS Rulemaking

Section 1102(a) of the Social Security Act (the Act) authorizes the Secretary to establish such rules and regulations as may be necessary for the efficient administration of the Medicaid and CHIP programs. The Medicaid statute at section 1902(a)(6) of the Act and the CHIP statute at section 2107(b)(1) of the Act require States to provide information that the Secretary finds necessary for the administration, evaluation, and verification of the States' program. Also, section 1902(a)(27) of the Act (and 42 CFR 457.950) requires providers to submit information regarding payments and claims as requested by the Secretary, State agency, or both.

Under the authority of these statutory provisions, CMS published a proposed rule on August 27, 2004 (69 FR 52620) to comply with the requirements of the IPIA and the OMB guidance. Based on the methodology developed in the PAM and PERM pilot projects, the proposed rule set forth provisions for all States annually to estimate improper payments in their Medicaid and CHIP programs and to report the State-specific error rates for purposes of computing the national improper payment estimates for these programs. The intended effects of the proposed rule were to have States measure improper payments based on FFS, managed care, and eligibility reviews; to identify errors; to target corrective actions; to reduce the rate of improper payments; and to produce a corresponding increase in program savings at both the State and Federal levels.

After extensive analysis of the issues related to having States measure improper payments in Medicaid and CHIP, including public comments on the provisions in the proposed rule, CMS revised its approach. CMS adopted the recommendation to engage Federal contractors to review State Medicaid and CHIP fee-for-service (FFS) and managed care claims and to calculate the State-specific and national error rates for Medicaid and CHIP. Based on these rates, the Federal contractor will calculate the national eligibility error rate for each program. CMS also adopted the recommendation to sample a subset of States each year rather than to measure every State every year. CMS adopted these recommendations primarily in response to commenters' concerns with the cost and burden to implement the regulatory provisions at the State level that the proposed rule would have imposed on States.

Since CMS' revised approach departed significantly from the approach in the proposed rule, CMS published an interim final rule with comment period on October 5, 2005 (70 FR 58260). The October 5, 2005 interim final rule with comment period responded to the public comments on the proposed rule, and informed the public of the national contracting strategy and of the plan to measure improper payments in a subset of States. A State will be measured once, and only once, every 3 years for each program. For each fiscal year, CMS stated that it expected to measure up to 18 States.

In the October 5, 2005 interim final rule, CMS stated that it was still possible that States sampled for review would be required to conduct eligibility reviews as described in the

proposed rule. CMS also announced its intentions to establish an eligibility workgroup to make recommendations on the best approach for reviewing Medicaid and CHIP eligibility within the confines of current statute, with minimal impact on States and additional discretionary funding. CMS convened an eligibility workgroup comprised of DHHS (including CMS and, in an advisory capacity, the Office of the Inspector General (OIG)), OMB, and representatives from two States. CMS determined that States should conduct the eligibility measurement and developed an eligibility measurement methodology based on the workgroup's consideration of public comments, the examination of various approaches proposed in such comments, and the suggestions of the panel members. The October 5, 2005 interim final rule also set forth the types of information that States would submit to the Federal contractors for the purpose of estimating Medicaid and CHIP FFS improper payments and invited further comments on methods for estimating eligibility and managed care improper payments. CMS received very few comments regarding managed care and a number of comments regarding eligibility.

Based on the public comments and recommendations from the eligibility workgroup, CMS published a second interim final rule on August 28, 2006 (71 FR 51050), which set forth the methodology for measuring improper payments in Medicaid and CHIP FFS, managed care, and eligibility in 17 States per cycle and invited further public comments on the eligibility measurement. The Centers for Medicare & Medicaid Services (CMS) implemented the PERM program in a final rule published on August 31, 2007 (72 FR 50490). The August 31, 2007 final rule responded to the public comments on the August 28, 2006 IFC and finalized State requirements for submitting claims to the Federal contactors that conduct FFS and managed care reviews. The final rule also finalized State requirements for conducting eligibility reviews and estimating payment error rates due to errors in eligibility determinations.

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

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

The CHIPRA requires a new PERM rule and delayed any calculation of a PERM error rate for CHIP until 6 months after the new PERM rule is effective. Additionally, the CHIPRA provides that States that were scheduled for PERM measurement in fiscal year (FY) 2007 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2007, or may elect instead to consider its PERM measurement conducted for

FY 2010 as the first fiscal year for which PERM applies to the State for CHIP. Similarly, the CHIPRA provides that States that were scheduled for PERM measurement in FY 2008 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2008, or may elect instead to consider its PERM measurement conducted for FY 2011 as the first fiscal year for which PERM applies to the State for CHIP.

The CHIPRA requires that the new PERM rule include the following:

- Clearly defined criteria for errors for both States and providers.
- Clearly defined processes for appealing error determinations.
- Clearly defined responsibilities and deadlines for States in implementing any corrective action plans.
- A provision that the payment error rate for a State will not include payment errors based on a State's verification of an applicant's self-declaration if a State's self-declaration verification policies meet regulations promulgated by the Secretary or are approved by the Secretary.
- State-specific sample sizes for application of the PERM requirements to CHIP PERM.

In addition, the CHIPRA shall harmonize the PERM and MEQC programs and provides States with the option to apply PERM data resulting from its eligibility reviews for meeting MEQC requirements and vice versa, with certain conditions.

As required by the CHIPRA, CMS proposed revised MEQC and PERM provisions in the proposed rule published in the July 15, 2009 Federal Register (74 FR 34468). CMS implemented a revised program through a final PERM rule published on August 11, 2010 (75 FR 48815). In addition to the provisions required by CHIPRA, the new rule addresses claims universe, sampling and review; the eligibility universe, sampling and review; error determination and rate calculation; difference resolution and appeals; and corrective action.

10.4 - Definitions

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. This definition applies to both the claims and eligibility.

Adjudicated claim: In reference to denied claims, an adjudicated claim is one that has been accepted and reviewed by the claim processing system and the decision to deny the claim has been made. In reference to paid claims, an adjudicated claim refers to a

submitted claim that has been accepted and fully reviewed and a positive determination has been made regarding the payment amount. For denied claims, the adjudication date should be used to determine whether a claim is included in a fiscal quarter if the State system does not capture a "paid date" for these claims. For paid claims, the date paid should be used for this determination.

Adjustment: Change to a previously submitted claim that is linked to the original claim.

Agency: Agency means, 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 fee-for-service claims, managed care payments, or eligibility cases necessary to meet precision requirements in a given PERM cycle.

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

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

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

Capitation: A fixed payment, usually made on a monthly basis, for each beneficiary enrolled in a managed care plan or for each beneficiary eligible for a specific service or set of 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. The case as a sampling unit only applies to the eligibility component.

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

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

Children's Health Insurance Program (CHIP): A program authorized and funded under Title XXI of the Social Security Act. Federal regulations governing this program are at 42 CFR Part 457.

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

Claim: A request for payment, on either an approved form or electronic media, for services rendered generally relating to the care and treatment of a disease or injury or for preventative care. A claim may consist of one or several line items or services.

Denied claim or line item: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment and not approved for payment in whole or in part.

Difference resolution: A process that allows States to dispute the CMS contractor's error findings.

Encounter data: Encounter data or "shadow claims" are defined as informational-only records submitted to a State by a provider or MCO for services covered under a managed care capitation payment. These data are often collected by a State in order to track utilization, assess access to care, and possibly compute risk adjustment factors for at-risk managed care contractors, but are not claims submitted for payment.

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

Eligibility error: An eligibility error occurs when a person is not eligible for the program or for a specific service and a payment for the sampled service or a capitation payment covering the date of service has been made.

Fee-for-service (FFS): A traditional method of paying for medical services under which providers are paid for each service rendered.

FFS processing error: A payment error that can be determined from the information available from the claim or from other information available in the State Medicaid/CHIP system (exclusive of medical reviews and eligibility reviews).

Finite Population Correction (FPC) factor: A statistical calculation that may be employed by the State or SC to determine sample sizes as an alternative to the base rates when sampling programs in which the total (full year) sample is drawn from a population of less than 10,000 individuals/claims.

Health Insurance Premium Payment (HIPP) program: A program allowing States to choose to have Medicaid or CHIP pay beneficiaries' private health insurance premiums when it is more cost-effective than paying for the full cost of Medicaid or CHIP services.

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 beneficiary, 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.

Individual reinsurance: In the context of PERM managed care universe files, individual reinsurance payments are those payments made by the State to a managed care plan for an individual beneficiary whose cost of care has exceeded a predetermined maximum amount, usually measured on an annual basis or on the basis of a specific episode of care. Such payment by the State typically represents a cost sharing arrangement with a managed care plan for extremely high-cost enrollees. Individual reinsurance may be based on the costs associated with all services provided by the managed care plan, or may be limited to excessive costs associated with certain services (e.g., transplants). (Note: providers whose payment rates are fully reconciled for actual costs incurred, on a retrospective basis, are considered to be FFS.)

Kick payment: Supplemental payment over and above the capitation payment made to managed care plans for beneficiaries utilizing a specified set of services or having a certain condition.

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.

Line item: An individually-priced service presented on a claim for payment. Items individually listed but priced in a bundled service rather than being priced individually are not considered "line items."

Managed care: A system where the State contracts with health plans on a prospective full-risk or partial-risk basis, to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered.

Managed Care Organization (MCO): An entity that has entered into a risk contract with a State Medicaid and/or CHIP agency to provide a specified package of benefits to Medicaid and/or CHIP enrollees. The MCO assumes financial responsibility for services delivered and is responsible for contracting with and reimbursing servicing providers. State payments to MCOs are typically done on the basis of a monthly capitation payment per enrolled beneficiary.

Medicaid: A joint Federal and State program, authorized under Title XIX of the Social Security Act (the Act) that provides medical care to people with low incomes and limited resources.

Medicaid Eligibility Quality Control (MEQC): A Federal program requiring States to annually assess Medicaid beneficiaries' eligibility, according to statistically reliable samples of cases selected from the State eligibility file. States may choose 'traditional' MEQC programs, where the sample draws from the entire Medicaid population, or they may implement 'pilot' MEQC reviews that focus on a particular Medicaid program and population sub-set.

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

Medicaid Statistical Information System (MSIS): The MSIS, housed by CMS, collects statistical data from each of the States on an annual basis (using form HCFA-2082). The system includes aggregated statistical data on beneficiaries, services, and expenditures during a Federal fiscal year (i.e., October 1 through September 30).

Medical review error: An error that is determined from a review of the medical documentation in conjunction with State medical policies and information presented on the claim.

Medicare: The federal health insurance program for people 65 years of age or older and certain younger people with disabilities or End Stage Renal Disease. Beneficiaries must pay (or have paid on their behalf) premiums for the two main portions of Medicare: Part A (hospital) and Part B (physician) services.

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.

Non-claims based sampling unit: Sampling units that are not related to a particular service provided, such as Medicare Part A or Part B premiums.

Overpayment: Overpayments occur when the State pays more than the amount the provider was entitled to receive or paid more than its share of the cost.

Paid claim: A claim or line item that was accepted by the claims processing or payment system, adjudicated for payment, determined to be a covered service eligible for payment, and for which a payment was issued or no payment was due to circumstances such as payment by a third party insurer.

Partial error: Partial errors are those that affect only a portion of the payment on a claim.

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.

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.

Primary Care Case Management (PCCM): A program in which beneficiaries are linked to a primary care provider who coordinates their health care. Providers receive small additional payments to compensate for care management responsibilities, typically on a per member per month basis. Providers are not at financial risk for the services they provide or authorize.

Program of all-inclusive care for the elderly (PACE): A benefit that States may at their option offer to Medicaid beneficiaries age 55 or older who have been determined to require the level of care provided by a nursing facility. Qualifying beneficiaries receive all Medicaid-covered services through the PACE provider in which they enroll. PACE providers must meet minimum federal standards and are paid on a capitation basis.

Provider error: This includes, but is not limited to, medical review errors as described in § 431.960(c) of this subpart, as determined in accordance with documented State or Federal policies or both.

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.

Risk-based managed care: The MCO assumes either partial or full financial risk, and is paid a fixed monthly premium per beneficiary.

Sample: A random sample of claims or cases selected from the universe (see "universe" definition below).

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

Sampling unit: The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, a month of enrollment in a managed care plan or a monthly Medicare premium). Depending on the universe (e.g., fee for service or managed care), the sampling unit includes: claim, line item, premium payment, or capitation payment.

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: This includes, but is not limited to, data processing errors and eligibility errors as described in § 431.960(b) and (d) of this subpart, as determined in accordance with documented State or Federal policies or both.

Stop-loss See "Individual Reinsurance," above.

Supplemental payments for specific services or events: These are payments that may be made by the State to a managed care organization on behalf of a particular enrollee in the

managed care plan, based on the provision of a particular service or the occurrence of a particular event, such as childbirth.

Third party liability (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. In cases of available TPL, Medicaid is payer of last resort.

Technical error: Errors in eligibility which would not result in a difference between the amount that was paid and the amount that should have been paid (i.e. an improper payment).

Underpayment: Underpayments occur when the State pays less than the amount the provider was entitled to receive or less than its share of cost.

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.

Universe: The universe is the set of sampling units from which the sample for a particular program area is drawn and the set of payments for which the error rate is inferred from the sample. The term "claim" is used interchangeably with the term "sampling unit."

Zero-paid claim: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and approved for payment, but for which the actual amount remitted was zero dollars. This can occur due to third-party liability, application of deductibles, or other causes.

10.5 - PERM Partners and Their Responsibilities

CMS contracts with two vendors to conduct the fee-for-service and managed care components of the PERM measurement and calculate error rates, a Statistical Contractor (SC) and a Review Contractor (RC). The SC is responsible for collecting and sampling claims and capitation payment data for review by the RC, supporting the States in the eligibility sampling process, and calculating State and national error rates. The RC is responsible for collecting State policies, obtaining medical records for sampled payments, and conducting data processing and medical reviews. States are responsible for conducting the eligibility component of the PERM measurement and reporting data to the SC for inclusion in the error rates. Additional information on the responsibilities of the SC and RC is provided below.

A. Statistical Contractor

The Statistical Contractor (SC) has three primary responsibilities: collecting and sampling claims and capitation payment data for review by the Review Contractor, supporting the States in the eligibility sampling process, and calculating State and national error rates.

Collecting and sampling claims and capitation payment data: Each quarter throughout the fiscal year, the SC collects the universe of claims data for Medicaid and CHIP FFS and managed care from the States. The universe includes claims that are paid with Federal

Financial Participation (FFP) for Medicaid and CHIP services. The SC draws a random sample of claims from the quarterly universes submitted by the State. After drawing the samples, the SC sends the samples to the Review Contractor (RC). The SC also sends the States a list of their sampled claims, and States populate the claims with detailed service and payment information. After the samples are populated and returned to the SC, the SC standardizes the format of the claims data and sends it to the RC for medical records requests and medical reviews.

Supporting the States in the eligibility sampling process: The SC reviews the Medicaid and CHIP eligibility sampling plans for the selected States. For each plan the SC disapproves, the SC shall work with the State to quickly resolve the issue(s) that resulted in disapproval and assist the State to correct the sampling plan in order to obtain approval. The SC hosts and maintains the internet-based PERM Eligibility Tracking Tool that allows States to submit PERM eligibility deliverables. The SC calculates State-specific eligibility error rates but also provides States with an error rate calculator and trains the States on the use of the error rate calculator.

Calculating State and national error rates: The SC calculates, for Medicaid and for CHIP, State-specific FFS, managed care, and eligibility error rates; State-specific program error rates based on the FFS, managed care, and eligibility error rates; national FFS, managed care, and eligibility error rates; and national program error rates based on the national Medicaid FFS, managed care, and eligibility error rates. The SC also projects the total number of FFS and managed care errors by State and nationally; the total dollars in error due to FFS, managed care, and eligibility errors, by State and nationally; the total dollars in error for the program, by State and nationally; the rolling error rate; and State-specific Medicaid FFS, managed care, and eligibility sample sizes for the next PERM cycle.

B. Review Contractor

The Review Contractor (RC) also has three primary responsibilities: collecting State policies, obtaining medical records for sampled payments, and conducting data processing and medical reviews.

Collecting State policies: The RC researches and obtains State Medicaid and CHIP policies that are used for the medical and data processing reviews.

Requesting medical records: When the RC receives sampled claims detailed data from the SC, the RC contacts those providers whose FFS claims were sampled to obtain copies of medical records for the claims in question. If the record does not contain sufficient documentation, the RC requests additional documentation from the provider.

Conducting data processing and medical record reviews: When the RC receives the sample list from the SC, the RC schedules on-site data processing reviews with each of the States. For FFS claims, the data processing review includes examining line items in each claim to validate that it was processed correctly. The RC also performs data processing reviews on managed care claims for the accuracy of the processing of the capitation

payment or premium. The RC also begins medical reviews on FFS claims. (Managed care claims are not subject to medical reviews because there is no specific service rendered on which to make a medical necessity determination.) The RC examines the medical record to ensure there is documentation that supports the claim billed, medical necessity, and coding accuracy.

10.6 - PERM Cycles

To estimate a national error rate for Medicaid and CHIP, it is not necessary to measure the error rate in every State; error rates for a subset of States can be established, and from these a national error rate can be extrapolated. In 2005 CMS published an interim final rule that described the plan to measure improper payments in a subset of States. One-third of the States would be measured each year, and from this subset of States, CMS would calculate a national error rate for Medicaid and CHIP representing the program error rate across all 51 Medicaid and CHIP programs.

CMS uses a rotational approach to review the States' Medicaid programs, so that each State is measured once every three years. At the end of the first 3-year cycle, the rotation will repeat so that the FY 2006 States were reviewed again in FY 2009; the FY 2007 States were reviewed again in FY 2010; and the FY 2008 States were reviewed again in FY 2011.

The States and their assignment within the rotation cycles are listed in Exhibit 1 below.

Exhibit 1. Medicaid and CHIP Measurement Cycles

Cycle	Includes Payments from These Fiscal Years	States
One	FY 2006 FY 2009 FY 2012 FY 2015	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Two	FY 2007 FY 2010 FY 2013 FY 2016	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Three	FY 2008 FY 2011 FY 2014 FY 2017	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

A. Timeline

Exhibit 2 provides a timeline of major PERM activities for the States, SC, and RC for claims and eligibility activities and a high-level timeline. Specific claims and eligibility timelines with due dates are addressed in section 20 Claims Universe and Sampling and section 80 Eligibility Reviews.

Exhibit 2. PERM Process Timeline

Timeframe	Event
August 1 (prior to federal fiscal year being measured)	States submit eligibility sampling plans to the CMS contractor for approval
October 1 (beginning of federal fiscal year being measured)	Claims and eligibility review process begins State orientation meetings with CMS, SC, and RC
November 15	States select first monthly eligibility sample (for October) and begin reviews; subsequent samples submitted each month on the 15th
December 1	RC researches and obtains States' Medicaid and CHIP medical policies in effect for the review period
January 15	States submit 1st quarter (October – December) adjudicated claims to the CMS contractor
February 1	RC researches and obtains States' 1st quarter policy updates
March 31	States submit results of eligibility reviews for first month sampled (October); subsequent month review results submitted on the last day of each month
April 15	States submit 2nd quarter (January – March) adjudicated claims to the CMS contractor
April	RC begins medical record requests when detailed data is received from the SC
May 1	RC researches and obtains States' 2nd quarter policy updates t
May	RC begins data processing orientation visits when sampler files are received from the SC
May 15	States submit results of eligibility payment reviews for first month sampled (October); subsequent month review results submitted on the last day of each month
July	RC begins data processing reviews on-site or remotely
July 15	States submit 3rd quarter (April – June) adjudicated claims to the CMS contractor
August 1	RC researches and obtains States' 3rd quarter policy updates

Timeframe	Event
September (last month of fiscal year being measured)	RC begins medical reviews
October 15	States submit 4th quarter (July – September) adjudicated claims to the CMS contractor
October 15	States select final monthly eligibility sample (for September)
November 1	RC researches and obtains States' 4th quarter policy updates
February 28	States submit results of eligibility reviews for final month sampled (September)
April 15	States submit results of eligibility payment reviews for final month sampled (September)
July 1	States submit eligibility error rate and findings to the CMS contractor
July 15	CMS cycle cut-off date
August	RC submits final findings to the SC SC calculates error rates
November	National rates published in Agency Financial Report States notified of state error rates and preliminary state-specific sample sizes for the following cycle
Throughout PERM process	States identify and resolve differences in review findings with the CMS contractor or through the State eligibility appeals process

20 - Claims Universe and Sampling

The PERM methodology is based on sampling and review of individual payments from a "universe" of State Medicaid and CHIP payments to identify payment errors, from which State and national-level program error rates are extrapolated.

The PERM claims universe includes payments that were originally paid (paid claims) and for which payment was requested but denied (denied claims) during the federal fiscal year under review, and for which there is federal financial participation (FFP), or would have been if the claim had not been denied, through Title XIX or Title XXI. This includes payments for services such as physician services, inpatient services, long term care, prescription drugs, and full-risk capitation payments, as well as a variety of special services and programs such as primary care case management (PCCM) payments, health insurance premium program (HIPP) payments, and capitated non-emergency transportation (NET) payments.

The PERM error rates are intended to be representative of the Medicaid and CHIP programs as a whole, and the methodology is predicated on being consistent across States and representative of total program spending. The PERM States and the SC work together to define and compile the PERM universe, from which the SC then selects the PERM sample.

This section describes the payments that are included and excluded from the PERM measurement and the sampling process for these payments. The universe definition and sampling process for the PERM eligibility component is addressed in Section 30 – Eligibility Universe and Sampling. Specific instructions for compiling and submitting conforming universe data will be provided to States each cycle.

20.1 - Claim Universe Definitions

The PERM universe definition is based on IPERA statutory requirements, OMB guidance, and the PERM regulation. The scope of the PERM universe is bound by the following parameters, each of which is described in more detail below:

- Date
- Program
- Payment type

There are also specific exclusions from the PERM universe, which are described at the end of this section.

A. Date

PERM universes include claims and payments originally paid (or denied) only during the federal fiscal year under review. For example, for the FFY 2011 PERM cycle, the State's PERM universe includes claims and payments originally paid between October 1, 2010 and September 30, 2011.

To support consistency across States, PERM relies on the original paid date to determine whether a payment falls within a given cycle measurement. If a State originally paid a claim during the cycle under review, but adjusted the claim after the PERM measurement period, the claim should be included in the PERM measurement based on the original paid date. Conversely, if a claim's original paid date is prior to the PERM measurement period, but an adjustment falls within the PERM measurement period, the claim would **not** be included in the PERM measurement, again, based on the original paid date. See Section 20.2 below for more information on the treatment of adjustments in PERM.

If States make payments for prospective or retrospective periods of coverage, the payment should be included as of the actual paid date. For example, if a State makes a capitation payment on September 25, 2011 for coverage in October 2011, a State being measured for the October 1, 2010 to September 30, 2011 measurement should include the payment, even

though the State is purchasing coverage for a period outside the fiscal year being measured.

B. Program

OMB guidance on program payment error rate measurement directs HHS to provide erroneous payment information under IPERA for the Medicaid program and CHIP program. So that the SC can calculate separate program error rates, PERM universes are divided between claims with FFP through Title XIX and claims with FFP through Title XXI.

PERM universes only include claims for which there is FFP through Title XIX or Title XXI. Payment for services provided to Medicaid beneficiaries or processed through MMIS but for which the State claims no Title XIX or Title XXI FFP ("State only" claims or programs) are excluded from the PERM measurement.

1. Title XIX/Medicaid

The PERM Medicaid universe includes payments matched with Title XIX funds. This includes claims for services provided to Medicaid beneficiaries. Claims for services provided to beneficiaries in Medicaid expansion-type CHIP programs (where beneficiaries are enrolled in Medicaid, but their claims are matched with Title XXI funding) are **not** included in the PERM Medicaid universe.

2. Title XXI/CHIP

The PERM CHIP universe includes payments matched with Title XXI funds. This includes claims for services provided to CHIP beneficiaries in standalone CHIP programs as well as services provided to beneficiaries in Medicaid expansion-type CHIP programs (where beneficiaries are enrolled in Medicaid, but their claims are matched with Title XXI funding). If a State has both a standalone CHIP program and a Medicaid expansion-type CHIP program, the payments from both programs will be combined to form a PERM CHIP universe.

3. Service expenditures and administrative expenditures

PERM universes include only payments representing services paid or denied (or for managed care, a capitation payment purchasing a package of services). PERM includes payments made for services received by individual beneficiaries that are matched at the medical services match rate or that receive FFP as an allowable administrative cost.

PERM universes do not include payments solely made for administrative functions, such as payments to fiscal agents, salaries of State employees, or funding for program outreach. In instances where rates blend administrative and service payments, the entire payment is included in the PERM universe.

C. Payment type

1. All payments

IPERA defines an improper payment as a payment that should not have been made or that was made in the incorrect amount, including overpayments and underpayments. Because denied claims could include underpayments, PERM universes include both paid and denied claims. CMS defines a paid or denied claim as a fully adjudicated claim that is resolved to either a "paid" status or a "denied" status. Paid claims include claims with a positive paid amount as well as claims with a paid status but a zero-pay amount.

Claims that are either in process or are suspended for review are not considered full adjudicated and are not included in the PERM universe. Rejected claims (e.g., claim batches rejected by a pre-processor for not conforming with 837 specifications) that are not adjudicated are also not included in the PERM universe. In a limited number of cases, denied claims may not contain sufficient information to assign the claim to the appropriate PERM universe (e.g., lack adjudication date, lack program assignment). These denied claims are also excluded from PERM.

PERM also considers only the original paid amount and any adjustments made to the payment within 60 days of the original paid date. The original paid amount included in the PERM universe should include the full amount for which federal matching funds are claimed. If a payment is processed in such a way that a portion of the full amount is not "paid" (e.g., a certified public expenditure, in which the paid amount to the public provider represents only the federal share of the payment), the amount in the PERM universe may need to be adjusted by the State to reflect the entire claimed amount.

2. Beneficiary-level claims and payments

PERM universes include claims and payments that are made by the State (or would have been made if the State had not denied payment) for services rendered to individual beneficiaries or for capitation payments made to purchase a package of services for an individual beneficiary. Beneficiary-level claims and payments represent, by far, the largest proportion of data in the PERM universe. Typical beneficiary-level claims and payments include fee-for-service (indemnity) payments, managed care premium payments, and other fixed payments, such as primary care case management payments.

Fee-for-service: Fee-for-service (FFS) is a traditional method of paying for medical services under which providers are paid for each service rendered. FFS payments in Medicaid and CHIP generally include individual physician, clinic, and hospital claims processed through the MMIS or other payment systems, including other State agencies and third party administrators.

Managed care: Managed care is a system where the State contracts with health plans on a prospective full-risk or partial-risk basis, to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered. Managed care payments can include capitation payments made to an MCO for a comprehensive package of services (full capitation), for a

limited package of services (partial capitation), or for specialty managed care programs for which the capitated provider is at risk (e.g., PACE programs, capitated behavioral health managed care programs).

Managed care payments may also include supplemental negotiated rate payments made to managed care plans on behalf of individual managed care enrollees, such as maternity "kick" payments or delivery supplemental payments and certain reinsurance or stop-loss payments. In some States that do not have HMO-type managed care plans, States may make premium payments to an insurer to purchase full-risk indemnity coverage.

In some cases, the single state agency or Medicaid or CHIP agency may make payments or transfers to other another state agency or program on a capitated or per-member-per-month basis using either budgetarily-derived payment amounts or actuarially-certified capitation amounts. Payments from one state agency to another are not treated as managed care for PERM purposes, because state agencies, even those operating as public MCOs, are not entities that assume risk. In these cases, the underlying fee-for-service payments made by the capitated state agency would be collected and reviewed for PERM. Reviewing the payments made by a state agency that is responsible for paying providers using Medicaid and/or CHIP dollars allows the State and CMS to have an estimate of improper payments made at the state level.

Other beneficiary-level claims and payments: Medicaid and CHIP programs may make a variety of other types of payments on behalf of individual beneficiaries. These may include primary care case management (PCCM) payments to primary care physicians, payments made to individuals or managed care organizations through Health Insurance Premium Payment (HIPP) programs, Medicare premium payments made on behalf of Medicaid beneficiaries (dual eligibles), certain reinsurance payments to managed care organizations, drug administration capitations to nursing facilities, and capitated non-emergency medical transportation payments to brokers. States may need to discuss certain payments, such as special incentive payments, or payments made under an 1115 waiver to non-enrolled beneficiaries, with CMS and the SC to determine if they are appropriate for inclusion in the PERM universe.

3. Aggregate payments

While most Medicaid and CHIP payments for services are paid at the beneficiary level, States also calculate and pay for some services on behalf of a group of beneficiaries. PERM broadly refers to these as "aggregate payments." Unless otherwise specified by CMS, aggregate payments for services are included in the PERM universe. Aggregate payments are included in the PERM universe regardless if the State claims FFP at the medical services match rate or as an allowable administrative cost.

Examples of aggregate payments are pay-for-performance incentive payments made to individual providers based on the claims experience of a group of beneficiaries; reimbursement to counties for non-emergency transportation services provided to all Medicaid beneficiaries residing in that county; and fees paid to a case management vendor based on the number of beneficiaries enrolled in the Medicaid program each month.

In some cases, States may determine payment at the individual level but maintain payment records at the aggregate level. In these cases, CMS and the SC will work with the State to determine how the payment should be submitted and reviewed for PERM.

D. Exclusions

The PERM regulation explicitly excludes a small number of specific payment types from the universe. These typically do not represent payments to individuals, either at the beneficiary-level or in aggregate. Regulatory exclusions include:

- Disproportionate Share Hospital (DSH) payments
- Grants to State agencies or local health departments
- Cost-based reconciliations to non-profit providers or federally-qualified health centers (FQHCs) not tied to individual claims

As noted above, PERM universes do not include payments solely made for administrative functions, such as payments to fiscal agents, salaries of State employees, or funding for program outreach. In addition, PERM universes do not include encounter data or "shadow claims." Encounter data is defined as informational-only records submitted to a State by a provider or a managed care organization for services covered under a managed care capitation payment. These claims are not linked to payments matched with either Medicaid or CHIP federal funds and are excluded from PERM.

20.2 - Claim Adjustments

As noted earlier, to support consistency across States, PERM relies on the original paid date to determine whether a payment falls within a given cycle measurement. The original paid amount is used to sort the payment for stratification and sampling purposes. However, many Medicaid and CHIP payments are adjusted, as discussed below.

Claims adjustments for Medicaid and CHIP are made through adjustments to individual claims and mass adjustments to claims.

Individual Claims Adjustments: In most cases, the provider or payer submits or processes an adjustment claim to correct a payment error. Adjustments to individual claims can be initiated by either the provider or by the payer.

- *Provider-initiated individual adjustments:* A provider can submit a request for a claim adjustment for a variety of reasons. In some cases the provider determines that the initial claim contained errors (e.g., billed for too few or too many procedures) which need to be corrected by the adjustment before the original claim is paid. In other cases the provider receives payment for the claim or the claim is denied, determines that the payment or denial was wrong because of erroneous information on the claim (e.g., incorrect beneficiary ID, missing procedure modifiers), and submits an adjustment.

- *State-initiated individual adjustments:* States may also adjust claims on an individual basis after they are initially paid. State surveillance and utilization review divisions routinely review claims to identify billing problems, potential abuse, etc. If a problem is detected with a specific claim, the State may adjust the claim to correct the payment. States also audit their own payment systems to ensure that edits and audits are working properly and may adjust claims if it is determined that a claim was paid in error due to a systems issue (e.g., failure to detect a duplicate, wrong fee schedule applied).

Mass Adjustments: States on occasion have to make mass adjustments to the payments they previously made to providers. The adjustments may be required for a number of legitimate reasons that are unrelated to payment errors. Probably the two most common examples of mass adjustments are due to changes in reimbursement rates to providers that cannot, for reasons beyond the control of the State agency, be implemented by their effective date, and cost-based rates for which final cost settlements necessarily are completed, in some cases, years after the payments are made. Another example is adjustments necessitated by State plan amendments that go into effect on a retroactive basis, or that are implemented prior to approval.

- *Changes in reimbursement rates to providers:* In some cases provider fee adjustments must be effective prior to the time that the claims payment system can be adjusted to reflect them. A typical example would be when a State legislature passes a law mandating fee increases (or decreases) by a certain date. Depending upon the proximity of the effective date, and the nature and timing of the State's regulatory process, the State agency may not be able to get implementing regulations promulgated by the effective date. In these cases, the Medicaid program legally must continue to reimburse at the old rates until the regulations take effect, at which time a mass adjustment to the paid claims is made to keep the providers whole. If a State did not use this mechanism to pay providers, and instead withheld any payment until the regulations incorporating the new rates took effect, there could be a potentially severe adverse impact on the providers' cash flow. In addition, the State might well be out of compliance with prompt payment requirements.

  Another example would be when providers successfully sue a State for having inadequate fees for certain services, in violation of the Title XIX statutory requirement that payment rates be consistent with economy, efficiency and quality of services. If the judicial remedy includes retroactive fee increases, the State is obligated to make mass adjustments.

- *Cost-based payment rates:* In many States, some Medicaid payment rates are cost-based. This is most frequently the case with certain institutional (hospital and nursing facility) payments, and formerly was required for Federally Qualified Health Centers and Rural Health Centers. For these providers, an interim rate is established and paid. After cost data are received and audited, a cost settlement is completed to establish the final cost-based rate. A mass adjustment is then made to account for the difference between the interim and final rates. In some cases, if the provider appeals the rate and wins, another mass adjustment may be required upon final adjudication.

- *State plan amendments:* States administer the Medicaid and CHIP programs according to Medicaid and CHIP approved State plans. When a State wishes to amend its program to add or discontinue benefits, expand or decrease beneficiary coverage and for other reasons, it will submit a State plan amendment that proposes the change for CMS approval. CMS has 90 days to approve or disapprove the proposed amendment (although CMS has the opportunity to stop-the-clock if, for example, more information is needed from the State on which to base a decision). Generally, if CMS approves the proposal, the effective date of the State plan amendment is retroactive to the beginning of the quarter in which the plan approval was granted. Note that, for CHIP, the effective date can vary.[1] Sometimes a State will implement new policies based on the provision(s) proposed in the State plan amendment even though the proposal has not yet been approved by CMS.

In PERM, the dollar amount in error is the difference between what *was* paid and what *should have been* paid, and can be the entire amount of the payment or a portion of the payment. The original paid amount is used to determine what was paid, and is compared to what should have been paid. However, if a payment is adjusted within 60 days of the original paid date, the adjusted amount will be used to determine what *was* paid, and compared to what should have been paid. Adjustments made outside of this 60-day window will not be considered. When the data processing reviews are conducted, the reviewer collects and considers all payment adjustment information made within 60 days of the paid date.

20.3 - Claims Sampling Units

The PERM methodology is based on sampling and review of individual payments from a universe of State Medicaid and CHIP payments (as specified above) to identify payment errors, from which State and national-level program error rates are extrapolated. Each payment, including FFS payment, capitation payment, or aggregate payment, is considered an individual "unit" for sampling purposes. Each sampling unit should be included in the PERM universe once and only once.

To promote consistency across States and across payment types, PERM considers the appropriate sampling unit to be the smallest level at which an individually-identifiable payment is made.

A. General sampling unit definitions

For most individual beneficiary-level claims and payments the sampling unit is a claim, line item, fixed payment, or other individually-priced service tied to a single beneficiary. If a State calculates the payment amount for a claim at the line item or "detail" level, the line is the sampling unit. The State would include all of the paid and denied lines for that claim

[1] In general, a CHIP amendment may remain in effect only until the end of the State fiscal year in which the State makes the amendment effective, or if later, the end of the 90-day approval period following the date on which the State makes it effective. Amendments related to a restriction in cost sharing, eligibility, enrollment or benefits may not be in effect for longer than a 60-day period.

in the PERM universe. For example, physician claims usually report an individually-priced service for each line of a claim (e.g., a claim may have five lines representing five individually-priced services). Since the paid amount for each line on the claim is determined independently of the other lines, the State would include each line in the PERM universe.

If the payment amount is calculated at the claim level (e.g., a DRG or per diem payment), the sampling unit is the header or claim level, and only the header information would be included in the PERM universe (supporting, unpriced lines for that claim would not be included). A hospital claim paid that pays on a DRG basis may include 20 additional lines, but the paid amount for all of the bundled services are calculated based on the DRG reported in the header. In this case, only the header level payment for the DRG should be in the PERM universe; the 20 lines on the claim are informational details and are not priced separately and so are not considered sampling units or included in PERM.

B. Claim-specific exceptions

States may need to identify claim-specific exceptions to payment level rules. For example, out-of-State hospitals might be excluded from the DRG system and pay each claim detail on a percent of charges basis. In this case, out-of-State hospital inpatient claims would be included in the PERM universe at the line level even though in-State hospital inpatient claims would be included at the header level. Other claim/provider types where there are often exceptions to the general header/detail payment rules include Medicare crossover claims, claims from federally-qualified health centers and rural health centers, and claims from State-owned facilities.

Third party liability may also affect the level at which a PERM sampling unit is assigned. If the State applies TPL only at the claim header level, the claim details cannot be used as the PERM sampling unit because the sum of the details would not equal the amount reimbursed by the State. In this example, the payment would be included in the PERM universe as a header level sampling unit to reflect the amount actually paid to the provider by the State.

For aggregate payments, the sampling unit for PERM is generally the lowest level for which a payment entry (record, invoice, or claim that the State uses to determine the payment amount) is available electronically. CMS, the SC, and the State may need to work together to determine the appropriate sampling unit for aggregate payments.

C. Adjustments

Each sampling unit must be included in the PERM universe once and only once. To avoid duplications of claims in the PERM universe, the sampling units are developed only based on original paid claims. Adjustments are not included in the PERM universe for sampling. In some cases, a State may “void” the claim and replace or resubmit the claim for adjudication with no connection (e.g., no ICN pointers, no mother/daughter linkages) between the voided and replacement claim. In these cases, PERM considers the voided claim and the replacement claim as separate sampling units.

20.4 - Claims Sampling Process

Because it would be impossible to review the accuracy of every Medicaid and CHIP payment made to a provider or managed care organization, CMS applies statistical techniques to draw a sample from the "universe" of Medicaid and CHIP payments, and then extrapolate from the review findings for the sample of payments to estimate the error rate for the universe of payments.

The IPERA requires an estimated national error rate bound by a 90 percent confidence interval of 2.5 percentage points in either direction of the estimate. That is, the sample must be large enough that, given standard statistical assumptions, one can be 90 percent confident that the error rate for the sample is within plus or minus 2.5 percentage points of the true error rate for the universe. Drawing a larger sample size can increase the confidence that the sample error rate is the same as the universe error rate, and/or decrease the size of the range around the estimate. CMS has chosen, for PERM, to draw samples at the State level that allow an estimated State error rate with a 95 percent confidence interval of 3 percentage points in either direction of the estimate.

Although separate samples are drawn for Medicaid and CHIP, the procedures for sampling are the same for both programs. This section distinguishes between Medicaid and CHIP only when differences occur.

A. Sample Size for Claims and Capitation Payments

Fee-for-service claims and capitation payments are sampled separately and component-level error rates for FFS and managed care are calculated as part of the State-level error rate calculation. If a State does not have any of the four components (i.e., Medicaid FFS, Medicaid managed care, CHIP FFS, CHIP managed care), that component is not sampled; no adjustments need to be made to the other component samples in that State.

For fee-for-service claims and capitation payments, the State-level PERM sample size is that determined necessary to calculate an estimated error rate for a State bound by a 95 percent confidence interval of three percentage points in either direction. In the initial PERM cycle, using data from the PAM and PERM pilots, the SC determined that sampling 1,000 FFS claims and 500 managed care payments from each State, using a stratified random sampling scheme, would likely be sufficient to achieve precision requirements. For subsequent cycles, CMS reduced the overall sample size by half. For FFS samples, approximately 500 items were selected during the year (125 per quarter). For the Medicaid and CHIP managed care program areas, the sample was reduced to 250 per year. (This implies selecting 62.5 items per quarter, which was rounded to 63.)

These sample sizes were the raw sample sizes and did not account for any oversampling performed to account for lines lost due to the inappropriateness of the line being in the universe, inadvertent data errors, or other statistical adjustments that may have been made. To account for the potential loss of sampled lines, CMS required that the sample size be increased by five items per quarter for each program area. (The SC selected one additional

item from each of the five strata. Exhibit 3 below has the final base year PERM target sample sizes.

Exhibit 3. PERM Base Year Sample Size (Per State, Per Program Area)

Base Year Quarterly Sample			
Program Area	**Base Sample Size**	**Additional Oversample**	**Total Base Year Sample**
Medicaid FFS, CHIP FFS	125	5	130
Medicaid Managed Care, CHIP Managed Care	63	5	68
Base Year Annual Sample			
Medicaid FFS, CHIP FFS	500	20	520
Medicaid Managed Care, CHIP Managed Care	252	20	272

As previously noted, on February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) was enacted. Section 601(f) of the CHIPRA requires CMS to establish State-specific sample sizes for application of the PERM requirements with respect to CHIP for fiscal years beginning with the first fiscal year that begins on or after the date on which the new final rule is in effect for all States, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable: (1) minimize the administrative cost burden on States under Medicaid and CHIP; and (2) maintain State flexibility to manage such programs. CMS published the final PERM rule on August 11, 2010 (75 FR 48815), therefore the State-specific sample size provision goes into effect with the FY 2011 PERM cycle (the first fiscal year that begins on or after the date on which the new final rule is in effect for all States).

The new rule establishes State-specific sample sizes for PERM, although the execution of these responsibilities remains with CMS and the Federal contractors, not with the States. Under the Secretary's authority at section 1102(a) of the Act and in order to effectively implement the IPERA, CMS applied these sampling procedures to both Medicaid and CHIP.

In addition, CMS also established a maximum sample size of 1,000 claims for each component. 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 claims, it is unlikely to be met with any reasonable sample size; however, a substantial increase in the probability of reaching precision goals can be gained by increasing the sample size from 500 to 1,000.

The SC will estimate State-specific sample sizes for each program component within each State based on the prior cycle's error rate (with the exception of FY2007 and FY2008

CHIP programs that elect not to accept a component of their CHIP PERM error rates from those cycles; if a State does not accept the component rate from the FY2007 or FY2008 cycle, the next measurement cycle for that State will be considered the "base year" for purposes of determining the State-specific sample size). The State-specific sample size must be sufficient to meet the precision requirements, which is to estimate the component error rate within three percentage points of the population mean error rate with a 95 percent level of confidence.

B. Claims Payment Stratification

PERM independently samples payments from four universes or program areas: Medicaid FFS, CHIP FFS, Medicaid managed care, and CHIP managed care. Generally, each program area is divided into strata based on payment amounts. The example below assumes five strata:

Step 1: The total amount of all payments is divided by five to determine the dollars that need to go into each stratum (20 percent of expenditures).

Step 2: All lines are sorted from largest to smallest payment amounts.

Step 3: Lines are selected in descending order until there are sufficient lines, added together, to represent 20 percent of expenditures. This is the first stratum.

Step 4: The second stratum consists of the next largest lines that represent 20 percent of expenditures.

Step 5: This sequence is repeated until all five strata are constructed. The fifth stratum always contains all denied lines (denials have a zero dollar amount and therefore will appear in the stratum with the smallest dollar values).

Step 6: An equal number of lines is then sampled from each of the strata (e.g., if the sample is to have 250 lines and there are 5 strata, 50 lines are sampled from each stratum).

Note that the first stratum will have the fewest number of lines (the lines in the first stratum are the highest-dollar lines, so it takes fewer of them to add up to 20 percent of expenditures), while the last stratum will have a very large number of lines. Therefore, this strategy has the additional implication that the sampling frequency in the first stratum, with the high dollar-valued lines items, will be greater than the sampling frequency on the last stratum, where very low dollar-line items are included. Put another way, higher-dollar claims have a greater chance of being sampled. See Exhibit 4 below.

Exhibit 4. Stratification by Expenditures – Five Strata (for CHIP FFS and Managed Care)

	Stratum 1	***Stratum 2***	***Stratum 3***	***Stratum 4***	***Stratum 5***	***Strata***
	(Largest claims)				**(Smallest, denials, zero paid)**	***All***

Number of lines	18,965	25,099	29,841	83,412	359,476	516,793
Percent of total	4%	5%	6%	16%	70%	100%
Total amount paid	$4,696,625	$4,696,748	$4,696,679	$4,696,770	$4,696,719	$23,483,540
Percent of total	20%	20%	20%	20%	20%	100%
Sample distribution	50	50	50	50	50	250
Sampling frequency	50/18,965 or 1 out of every 379	50/25,099 or 1 out of every 502	50/29,841 or 1 out of every 597	50/83,412 or 1 out of every 1,668	50/359,476 or 1 out of every 7,190	N/A

The Medicaid FFS program area uses a variation of this stratification approach that results in six strata instead of five. Because many States faced challenges in providing the Medicare premium payments for the Medicaid FFS program area, CMS agreed to create a sixth stratum in the Medicaid FFS program area consisting only of Medicare premium payments. A standard portion of the sample (4 percent) was allocated to Medicare premium payments based on expected expenditures. The remaining line items (all non-Medicaid premium payments) are stratified by payment amount into five 20 percent groups as discussed above.

Therefore, for Medicaid FFS, sample size for each non-Medicare strata is 25 and the Medicare strata is 5, while for CHIP FFS the sample size for each strata is 26, since there are no Medicare data. For managed care, as noted above the total sample size is 68 per quarter. Distributing 68 equally among the five payment strata is difficult. For consistency, each strata was assigned a sample size of 13, for a total of 65 samples, and the 3 remaining samples were distributed among the top three strata (strata having lines with the highest dollar values). Hence, for managed care, the top three strata have a sample size of 14 and the other two strata have a sample size of 13.

C. Claims Payment Sampling Process

Below are the steps followed to develop the sampling strata and extract the sample for one quarter for one State Medicaid FFS program area (130 claims). A similar process is used for the other samples, with the differences noted above.

Step 1: Divide the data into two groups, the Medicare premium payments and the remaining data.

Step 2: Sort all the non-Medicare premium data first by paid amount and then by a random number (the random number is used to order payments with the same dollar amounts).

Step 3: Calculate the total payments for the non-Medicare universe.

Step 4: Define strata, placing in descending order the lines into strata such that each stratum represents 20 percent of expenditures.

Step 5: The sample size for all non-Medicare strata is 20 percent of the total sample size for non-Medicare sample (25 lines), and the Medicare payment stratum sample size is 5 lines.

Step 6: Determine the skip factor for each stratum (denoted by k_i). Let N_i denote the universe number of claims for the i^{th} stratum in a State.

$$k_i = \frac{N_i}{n_i}$$

Step 7: Determine a random start value for each stratum (denoted by $start_i$), such that $1 \le start_i \le k_i$ (i denotes the i^{th} stratum).

Step 8: Sample every k_i^{th} item within the i^{th} stratum.

D. Modifications to the Claims Sampling Process

The previous section provides the sampling procedure when the universe information is accurate. In practice, problems with the universe data from States were often discovered after a sample had been drawn and details provided by the State and/or medical records requested. When problems with the universe file are discovered after the initial sample is sent to the State, the following steps are taken to correct the sample:

Step 1: A correct universe file was created using replacement data provided by the State.

Step 2: Sample sizes needed for each stratum were recalculated from the corrected universe file.

Step 3: All lines in the first sample that existed in the corrected universe file were left in the final sample, if this was possible to do so while preserving a valid sample.

Step 4: Additional sampling to eliminate any difference between the new required sample size for each stratum and portion of the first sample that was valid were sampled from the corrected universe file.

Step 5: Before sampling, all claims from the first sample were withdrawn from the corrected universe file and accurate sampling frequencies calculated.

Step 6: The sampling procedure described in the previous section was applied to the "add on" sample and the adjusted universe file.

Following these steps ensured the sample remained a simple random sample within strata and that accurate sampling frequencies could be calculated so that the population inferences would remain unbiased. There might be cases where this process resulted in

more than the required number of lines in a stratum due to the reallocation of the sample prescribed by the corrected universe file. There also might be cases where originally sampled lines existed in the universe, but were inappropriately placed in the wrong stratum. In this case, the sampled line would be moved to the correct stratum and remain a sampled line, even though the probability of that line being sampled was different from the other sampled lines in the stratum. This direction was taken, again, so that costs already incurred to request documentation and to review the item would not be wasted, and so that the timeliness of operations would not be impeded. Although this particular line had a different probability of being sampled, this was taken into account when making the population inferences.

20.5 - PERM Data Submission

CMS requires each PERM State to submit a universe of all original beneficiary-level payment records for Medicaid and CHIP, from which to select the random sample for review.

A. Routine PERM

The routine PERM data submission process requires two data submissions from the States. The first data submission contains a complete universe of original beneficiary-level payment records for Medicaid and CHIP. CMS requires that the universe data conform to a lengthy list of requirements to ensure consistency across States and with statistical sampling and error rate calculation methodologies. Once the PERM contractor has sampled from the universe files, each State must submit claim detail files for those payment records that were selected for audit. Typically, States must exchange data several times with CMS contractors to populate sampled claims with the details required for medical record requests and claim processing reviews.

Please reference Attachment 20-A for the routine PERM data submission instructions.

B. PERM Plus

PERM Plus is a data submission process developed by CMS to simplify PERM for States. Through PERM Plus, States submit claims, recipient data, and provider data at the beginning of each quarter. CMS' PERM contractor, not the State, is responsible for much of the data programming to develop a PERM universe, such as developing "sampling units" (figuring out if a claim or payment should be sampled at the header or line level based on the payment method, removing records that don't qualify for sampling). States submitting under PERM Plus do not have to develop the sampled claim detail information, as the PERM contractor will be responsible for merging provider and recipient information into the sampled claims.

Please reference Attachment 20-B for the PERM Plus data submission instructions.

C. Claims Data Submission Due Dates

States submit claims and payment data for routine PERM and PERM Plus on a quarterly basis. Data is due to the SC fifteen days after the end of each quarter as shown in Exhibit 5.

Exhibit 5. Claims Data Submission Due Dates

Quarter	Claim Date Paid	Data Submission Due
Quarter 1	October 1 – December 31	January 15
Quarter 2	January 1 – March 31	April 15
Quarter 3	April 1 – June 30	July 15
Quarter 4	July 1, 2011 – September 30	October 15

D. Claims Data Quality Review

States are required to review claims and payments data prior to submission and certify the accuracy and validity of the submission. Reference Attachments 20-A and 20-B for claims data quality review instructions and guidance on comparing PERM data to CMS Financial Management Reports.

E. Data Security

Under PERM, States submit documentation that contains protected health information (PHI), which includes individually identifiable health information (IIHI), for purposes of medical reviews and data processing reviews on paid claims. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CMS, its contractors, and States are all responsible for ensuring the security of electronic PHI (ePHI) and PHI that they maintain, transmit, disclose, or dispose. Information security requirements must safeguard against the potential breach of ePHI and PHI. CMS requires States, its contractors, and other business associates to adhere to Federal standards for the adequate encryption of PHI prior to transmission and that any passwords are sent securely and separately from the transmitted data, regardless of the method of transmission.

Under HIPAA, covered entities must ensure the secure transfer of ePHI and/or PHI contained in any data transmissions. To meet this requirement, CMS recommends all State data transfers containing ePHI and/or PHI be encrypted with software that is compliant with the Federal Information Processing Standards (FIPS) 140-2, and validated by the National Institute of Standards and Technology (NIST) module.[2] The software should also have key management, which allows the State's system administrator to have the authority to unlock all encrypted files from the State's system. This method prevents the necessity of

[2] FIPS 140-2 can be found at: http://www.csrc.nist.gov/publications/fips/fips140-2/fips1402.pdf. NIST module can be found at: http://www.csrc.nist.gov/groups/STM/cmvp/index.html

sharing the password with others at the State if the State contact person sending the data to the contractor is unavailable to provide the key.

In the event of a breach of ePHI, PHI, or IIHI, CMS requires States, its contractors, and other business associates to adhere to the breach notification rules as mandated under the Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act (ARRA) of 2009.[3]

The CMS contractors will provide States with instructions on data submission that meet CMS security requirements.

30 - Eligibility Universe and Sampling

30.1 - Eligibility 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' SC 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 will include a teleconference between the State, CMS, and the SC 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

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[3] The HIPAA Breach Notification Rule, released by OCR/HHS , applies to HIPAA covered entities. This Rule may be accessed at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html. The Health Breach Notification Rule, released by the FTC, applies to non-HIPAA covered entities. This Rule may be access at: http//ftc.gov/healthbreach/.

- List of the agencies in the State that make eligibility determinations and a State agency contact responsible for overseeing eligibility appeals
- 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 will be identified and included in the universe for sampling
    - 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 SC 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. Please see Attachment 30-A for an example of an eligibility sampling plan.

30.2 - Eligibility 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. 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).

Following CHIPRA, CMS has revised the definition of a "case" to mean an individual or family, at the State's option. (Note: A "family" may include just one beneficiary.) This new definition parallels the definition of a case used in MEQC, to support PERM-MEQC harmonization. For States where sampling at the individual beneficiary level is easier from a programming and/or review perspective, no changes to the State's existing PERM process need to be made. States that opt to sample at the family level will need to update their sampling plans accordingly.

The change in the definition of a case will not affect the methodology for calculating State error rates or the national error rate, as the case and payment error rates are calculated using the appropriate universe totals. States that sample at the individual beneficiary level will continue to submit the total number of individual beneficiaries in the universe each month. States that opt to sample at the family level will submit the total number of families in the universe each month.

A. 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 all active cases on the program at any time during the month (with the exception of cases that are receiving benefits during a retroactive period of eligibility).

1. Identifying the Active Case Universe

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

Exclusions from the active case universe are:

- All cases that were denied or terminated[4] (Note: These cases should be included in the negative universe);
- Cases under active fraud investigation (as defined in section 10.4);
- 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 option 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);

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[4] It should be noted that for PERM purposes, cases that are in suspended status due to certain penalties that have not met spenddown in the sample month are not included in the active case universe.
Suspended cases should only be included in the active case universe when the beneficiary is no longer under penalty and may receive program benefits.
Spenddown cases should only be included in the universe when spenddown is met or the case is no longer in a "pending" status. If stratifying the universe into the three PERM strata, suspended cases and spenddown cases would be included in Stratum 1 once spenddown is met, and Stratum 3 for any subsequent months in which the case remain active.

- For Medicaid only, Supplemental Security Income (SSI) cash cases in States with an agreement with the Social Security Administration (SSA) under Section 1634 of the Social Security Act; and
- For Medicaid only, adoption assistance and foster care cases under Title IV-E.

2. Sample Size for Active Cases

The base year sample size (i.e., the sample size to be used by States in their initial year conducting PERM eligibility reviews), calculated under the assumption that the error rate was 5 percent, is 504 active cases. Sample sizes must be sufficient to meet the precision requirements, which is to estimate the active case payment error rate within 3 percentage points of the population mean error rate with a 95 percent level of confidence.

After the base year, 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 be required to increase their sample size for the subsequent cycle. The SC will calculate sample sizes for subsequent years based upon the State's prior year eligibility error rate. CMS has established a maximum sample size for eligibility at 1,000 cases, regardless of a State's eligibility error rate in the prior cycle.

If the total population from which the total (full year) sample drawn is less than 10,000 individuals, the State may propose in its sample plan to reduce the sample size by the finite population correction (FPC) factor (as defined in section 10.4).

3. Method for Drawing the Monthly Sample

States will draw the sample 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 the "skip" factor method. Please see Attachment 30-B for information on how to stratify the universe and then draw a sample.

- 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. 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 nth 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 57, case number 107, etc. until the required 20 cases were drawn. States may include oversample cases with the required cases when using the "skip" factor method. However, as discussed in the following 'Adjustments to the Monthly Sample' section, States may want to draw an oversample in case any problems are discovered in the sample (active beneficiary fraud, etc.). When using the "skip" factor method of sampling, after the sample is drawn, the State will need to randomly select the cases which will be considered the oversample cases (taking the first two or last two cases is not random).

Note that over the course of the year, cases are likely to appear in the universe more than once and may be randomly sampled in more than one month, although it is unlikely. 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.

States in the base year will sample 42 cases each month for the twelve month Federal fiscal year. 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.

4. Adjustments to the Monthly Sample

If a State identifies a problem with the Medicaid and CHIP eligibility universes that would require changes to the sample, States should contact the SC immediately with specific information regarding why the sample is being changed. If problems are identified in the sample, the State must ensure that the universe totals are accurate. States may also need to resubmit a revised sample list to the eligibility review reporting 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 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 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.

5. States Substituting MEQC Data

Beginning with the FY 2009 cycle, States are provided the option to substitute MEQC data to meet the PERM eligibility review requirements. States electing to use this option must submit a modified MEQC sampling plan that meets MEQC requirements as well as applicable PERM requirements. The MEQC sample size must meet PERM confidence and precision requirements.

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

- Those cases for which Medicaid eligibility was determined by SSA in 1634 contract States;
- Cases eligible for Medicaid based on title IV-E adoption or foster care;
- Cases funded 100 percent by the Federal Government;
- Retroactively eligible cases; and
- Cases that have been approved for Medicaid or CHIP using the States' "Express Lane" eligibility option according to Section 1902(e)(13) or Section 2107(e)(1) of The Act.

Section 7230 of the SMM lists acceptable reasons for States to not complete an MEQC review on a case. If any of these reasons result in an "Undetermined" PERM finding as discussed in Section 80.1, these cases may be dropped for MEQC purposes, but **must not be dropped** for PERM. These cases must be verified for eligibility through other reasonable evidence or reported as Undetermined for PERM purposes. The acceptable reasons for States to drop a case from the MEQC review are:

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

B. 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 SC.

1. Identifying the Negative Case Universe

A unique universe is created each month. All cases where the State denied eligibility in the sample month or terminated eligibility in the sample month should be included in the negative universe for that month. All other active cases, including cases still on the program pending the required 10 day notice of termination and cases where benefits are properly being continued pending an appeal of termination, should be excluded from the negative case universe. There are no provisions for States to drop cases from review and replace them with other cases unless they do not belong in the negative case universe.

2. Sampling the Negative Case Universe

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

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.

After the base year, 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 be required to increase their sample size for the subsequent cycle. The SC will calculate sample sizes for subsequent years based upon the State's prior year eligibility error rate. CMS has established a maximum sample size for eligibility at 1,000 cases, regardless of a State's eligibility error rate in the prior cycle.

4. Method for Drawing the Monthly Sample

The initial sample will be drawn from this universe of negative cases over the entire twelve months of the Federal fiscal year. The sample size should consist of 17 cases 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 30.2.A for the methods for drawing a random sample.

5. Substituting Negative Findings

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

30.3 - MEQC/PERM Substitution

A. General Provisions

Section 601(e)(3) of the CHIPRA provides that for purposes of satisfying the requirements of the PERM regulation relating to Medicaid eligibility reviews, a State may elect to substitute data obtained through MEQC reviews conducted in accordance with section 1903(u) of the Act for data required for purposes of PERM, but only if the State MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the States. The CHIPRA's general effective date of April 1, 2009 applies to this provision. Therefore, as of April 1, 2009, States have the option to substitute MEQC data for PERM data so long as the MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the States.

CMS will allow States the option to substitute MEQC data for PERM data for purposes of the PERM reviews, but will require States to retain two separate, independent processes (MEQC and PERM), governed by separate statutes and regulations. As PERM is required to meet specific statistical precision requirements at the national level for IPERA and the MEQC error rate is not, CMS does not believe it is feasible to incorporate the MEQC error rate into a State's PERM error rate. Therefore, CMS will interpret "data" as the sample, eligibility review findings, and payment findings as measured under MEQC or PERM. CMS will calculate separate rates for each program.

States operating under MEQC waivers and pilot programs cannot substitute their MEQC data for PERM data because the CHIPRA only permits substitution of MEQC data for PERM reviews where the MEQC review is conducted under section 1903(u) of the Act, and the MEQC waivers and pilot programs are not conducted under the requirements of section 1903(u) of the Act. Additionally, the CHIPRA only permits substitution of MEQC data if the reviews are based on a "broad, representative sample" of Medicaid applicants and beneficiaries. MEQC Section 1115 waivers and pilot programs are special studies or conducted on focused populations of Medicaid beneficiaries and are not considered a representative sample of all Medicaid beneficiaries.

We interpret "broad, representative sample of Medicaid applicants or enrollees" to mean that States must develop the MEQC universe according to requirements at §431.814 in order to consider the option to use one program's findings to meet the requirements for the other. Under §431.814, States must sample from a universe of all Medicaid and Title XXI Medicaid expansion beneficiaries (except for the exclusions provided in §431.814(c)(4)). States operating MEQC pilots or waivers will need to continue operating PERM separately from MEQC.

Additionally, the MEQC samples must meet the PERM confidence and precision requirements. This means that the MEQC sample size may need to be adjusted to meet the PERM confidence and precision requirements if the State elects to substitute MEQC data for PERM data.

States with CHIP stand alone programs only have the option to substitute Medicaid MEQC data to meet the PERM Medicaid eligibility review requirement, as CHIP stand alone is not reviewed under MEQC.

States with Title XXI Medicaid expansion programs may use their MEQC reviews described in §431.812(a) through (e) to meet both the PERM Medicaid and CHIP eligibility review requirements, because both Medicaid and Title XXI Medicaid expansion are reviewed under MEQC. Title XXI Medicaid expansion data must be separated from the MEQC Medicaid data to calculate a PERM CHIP error rate.

States with combination programs in which a portion of their CHIP cases are under a stand-alone program and a portion of their CHIP cases are under a Title XXI Medicaid expansion program may use the MEQC reviews described under §431.812(a) through (e) to meet the PERM Medicaid eligibility review requirement and the portion of the PERM CHIP eligibility review requirement under Title XXI Medicaid expansion. However, the stand alone portion of the CHIP universe must remain separate and reviewed under PERM review guidance, because CHIP stand alone is not measured under the MEQC program. The SC will calculate State eligibility error rates, and will combine the Title XXI Medicaid expansion and CHIP stand alone findings to calculate one PERM CHIP error rate.

See Attachment 30-C for more information on MEQC & PERM Sampling and Review Differences.

B. Exceptions

While MEQC allows cases to be dropped from review under the conditions of Section 7230B of the SMM, undetermined cases must be included in the PERM error rate. Accordingly, all MEQC cases must be included in the PERM error rate calculation. States must complete an MEQC case record review, apply the requirements to the PERM review or cite the cases as undetermined. PERM cases cited as undetermined errors may, however, be dropped from the MEQC error rate calculation so long as the reasons for the dropped cases are in accordance with Section 7230B of the SMM.

C. Error Rate Calculations

States that choose to substitute MEQC or PERM data should note that two error rates are calculated. The SC will use the lower limit of the confidence interval that is typically used for MEQC and allowing drops for MEQC that are allowable in the SMM. For the PERM error rate the SC will use the midpoint estimate typically used for PERM and MEQC drops will be considered part of the PERM error rate. Only the MEQC error rate will be subject to disallowances under section 1903(u) of the Act. PERM does not have a threshold for eligibility errors and any improper payments identified during the eligibility measurement are subject to recovery according to §431.1002 of the regulations.

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.

D. 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.

E. Substituting Negative Case Findings

The August 2007 PERM final rule made effective the option for States to use PERM negative cases to comply with the negative MEQC case action requirements. A State does not have to substitute active case data to use this option.

F. Reporting

MEQC reporting requirements to the CMS Regional Offices remain the same, including reporting the error findings for the two, 6 month review periods, but States will also be required to comply with the PERM eligibility reporting deadlines by posting error findings to the PERM electronic eligibility findings repository specified by CMS.

40 - State Policy Submission Process

The RC is responsible for acquiring Medicaid and/or CHIP policies for each State selected for review for the PERM cycle and maintaining a database that contains a complete set of policies for each selected State governing their respective Medicaid and/or CHIP programs, and which govern claims under review during the PERM review cycle. Policies used in the PERM review may include:

- rules/regulations
- manuals/handbooks
- bulletins/updates/notices
- clarifications/reminders
- fee schedules/codes

The RC will contact each State at the beginning of each PERM review cycle. The RC begins the policy collection process by researching the State website(s) for all available State policy documents that contain Medicaid and/or CHIP policy documents relevant to the medical review of claims, and downloads these from the State website. If a policy update alert system exists, the RC will apply to receive updates of all policy changes from the State. The RC then downloads all policies, converts them to text-searchable formats if necessary, and compiles a master list of all policies for each State. After the completion of the Master Policy List, the RC sends the list of policies to the State and requests that they verify in writing that the list is complete (or supplemented when needed). The RC

continues to collect State policies throughout the measurement year, and validates the list with the State as appropriate.

50 - Medical Record Request Process

The Review Contractor (RC) is responsible for requesting all medical record documentation associated with the randomly selected Medicaid FFS claims. The requests will be submitted directly to the provider's medical record location as verified by the provider. Providers have a 75-day window to submit the medical record documentation. At a minimum, the RC will send four letters and make four phone calls to each provider throughout the 75-day window, as needed, to follow up on documentation not yet received. The user's guide for the website States can access to track medical record requests is included in Attachment 50-A.

A. Provider Contact Validation

The RC first verifies the provider information by contacting the billing provider by phone, using information provided in the claim details submitted by the State. The RC will provide information on the patient, date of service, and type of service and notify the provider that a written request is forthcoming. The RC will verify the provider's name, phone number, and mailing address where medical records can be obtained and determine to whom the letter should be addressed. The RC will also determine the preferred method for the request (fax or first class mail). If the RC is unable to verify the provider information on the States' claim files after using other means (e.g., internet, directory assistance) the RC will contact the State to obtain more current provider information.

B. Initial Medical Record Request

If the fax method is preferred, the RC will fax the PERM initial request letter package, with cover letter to the fax number provided within one hour of the telephone call or as reasonable during high volume times and constraints. If mail delivery is preferred, the RC will send the initial request letter package to the point of contact at the confirmed address via standard USPS first class delivery within one business day of the telephone contact.

The initial medical record request letter includes a brief introduction to PERM and contact information for RC representatives working on collection of medical records. The initial letter includes language informing the provider that a claim submitted by, or on behalf of, the provider was randomly selected for review and indicates that the State may seek recoveries for claims in which medical records are not received by the RC in a timely manner. The letter also describes CMS' authority to collect medical records under the Social Security Act; that CMS and its contractors will comply with the Privacy Act and the regulations at 45 CFR parts 160 and 164, and provide specific reference to the HIPAA standards, including language that the release of medical record and patient information is not a violation of HIPAA standards.

The letter includes details for the provider to identify the appropriate record (e.g., the beneficiary name; date of service; diagnostic code (ICD-9-CM); service code (CPT, HCPCS or prescription number); and total amount of claim or total amount for service.

The letter describes the specific documentation being requested (a request list is attached to the initial request letter) and asks that all medical documentation pertaining to the specific service rendered be submitted to the RC. Each claim is assigned a specific claim category, and claim category specific components (i.e., history and physical, plan of care etc.) of records are listed on the record documentation request list. Finally, the letter indicates that the provider has 75 days from the issue date of the letter to provide the requested medical record to the RC.

C. Follow-up Medical Record Requests

The RC will contact each provider who has not submitted the requested record information by telephone. The RC will also make up to three additional calls and send up to three additional letters that remind the provider of the date on which the 75-day clock will expire.

If the provider does not submit the requested information by the deadline, the RC sends a final letter that contains the detailed request information but also informs the provider that failure to submit the requested medical record resulted in a PERM error and that a notice will be submitted to State officials of the error, who may seek recoveries for claims in which medical records are not received by the RC in a timely manner.

D. Follow Up for Incomplete Documentation

The RC will process additional documentation requests when incomplete documentation is received from the provider. Once a medical reviewer identifies that there is incomplete documentation for a specific service, he or she will note specifically what documentation is necessary to complete the review and the RC will contact the provider by phone and send a letter to request the additional documentation. If the additional documentation has not been received within seven business days from the provider, a reminder call to the provider is made and a reminder letter is sent. If the additional documentation is not received from the provider within fourteen days, it will be counted as an insufficient documentation (MR2) error.

If the provider does not submit the requested information by the deadline, the RC sends a final letter that contains the detailed request information but also informs the provider that failure to submit the requested medical record resulted in a PERM error and that a notice will be submitted to State officials of the error, who may seek recoveries for claims in which medical records are not received by the RC in a timely manner.

E. Late Documentation Policy

In cases where the RC receives no documentation from the provider after 75 days have passed since the initial request, the RC will consider the case to be a no documentation

error. The RC will consider any documentation received after the 75th day to be "late documentation."

If the RC determines that the documentation submitted by the provider is insufficient to make a determination about whether or not the claim should have been paid, they will request additional documentation from the provider. Providers have 14 calendar days to submit the additional documentation to CMS. Additional documentation received after the 15th day will also be considered "late documentation."

If the RC receives late documentation prior the second July 1 in the PERM production cycle (the cut-off date for error rate calculation and reporting purposes), they will review the records and, if justified, revise the error finding. The RC will not review late documentation received for cases that have undergone a CMS appeal review or are in the CMS appeals process.

If late documentation is received after the cut-off date, the documentation will not be reviewed until after August 30 of that year. Any revised error finding will not be factored into the State's official error rate, although the State may request a recalculation of its error rate in certain circumstances.

60 - Data Processing Reviews

A data processing error is an error resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System, related systems, or outside sources of provider verification.

The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with the State's documented policies, is the dollar measure of the payment error.

Data processing (DP) errors include, but are not limited to the following:

- Payment for duplicate items
- Payment for non-covered services
- Payment for fee-for-service claims for managed care services
- Payment for services that should have been paid by a third party but were inappropriately paid by Medicaid or CHIP
- Pricing errors
- Logic edit errors
- Data entry errors

- Managed care rate cell errors
- Managed care payment errors

All FFS and managed care claims are subject to DP review. For FFS claims sampled at the header level, the data processing review includes examining all line items in each claim to validate that it was processed correctly. For FFS claims sampled at the line level, the data processing review includes examining the payment for the line that was sampled. DP reviews for managed care claims check for the accuracy of the processing of the capitation payment or premium.

The RC will request data processing manuals, systems navigational tools, and pricing guides prior to and during the DP orientation visit if not available on the States' websites. Some DP review tools may be gathered during the first on-site review or during remote reviews as needs or exceptions are identified.

60.1 - Basic FFS Data Processing Review Components

The following elements are reviewed during the data processing FFS review:

A. Verification of Beneficiary Information

In order for the CMS contractor to determine that the beneficiary was eligible for payment of the services under review, the following beneficiary information is reviewed:

- Date of birth/age
- Date of death
- Citizenship status
- City/zip code if needed to determine managed care status
- County of residence
- Sex/gender
- Beneficiary ID
- Living arrangements (home, institution, group home, other)
- Patient liability
- Patient level of care, if applicable
- Program eligibility and effective dates (relative to dates of service).

- Beneficiary residency requirement for enrolling in managed care plan/ or living in a mandatory managed care geographical area

B. Verification of Third Payer Liability (TPL) Payment Information

TPL and Medicare information is reviewed to determine whether another source was available to cover the service, and if so, whether it was considered in accordance with the State's TPL policy (cost avoidance, pay and chase).

- Medicare eligibility – Parts, A, B, and D with dates of eligibility
- Other TPL information including coverage dates and covered services.

C. Verification of Provider Eligibility

In order to verify that the provider(s) were registered and eligible to provide and bill for the services under review, the following provider information is reviewed:

- Provider Name
- Provider number
- Provider registration/enrollment
- Provider license, if required
- CLIA certification, if required
- Provider type and specialty
- Provider and service location
- Provider sanction/suspension periods

D. Verification of Accurate Claim Payment

In order to determine that the payment for a covered service was accurately calculated and paid, the following elements are reviewed:

- Whether the claim was filed within appropriate filing timeframes;
- The claim for a covered service (access to NDC, revenue codes, procedure code, etc. screens with information about parameters that apply to each code will be required);
- The pricing appropriate according to the fee schedule in effect for the date of service (access to rates e.g., DRG, per diem, max fee, provider specific, for all types of claims including rates for older dates of service is required. For example, if the State makes retroactive rate adjustments it will be necessary to access the rates that were in effect

for the DOS on the date that the claim under review was paid.) In addition, information about how the State calculates each type of payment is required.

- The ability to complete a duplication check by the CMS contractor.
- If the State processes payments for "sister agencies" that receive pass-through FFP at the federal match rate, (i.e. Medicaid in public schools, mental health) this information needs to be identified so pricing can be accurately determined.
- If provider filed a hard copy claim, access to the scanned image of the claim as well as the system information is required.
- Any adjustments made to the sampled claim.
- Access to tables that explain codes used in the system (if not contained in system help).

60.2 - Basic Managed Care Data Processing Review Components

A. Verification of Beneficiary Information

In order for the CMS contractor to determine that the beneficiary was eligible for payment of the services under review, the following beneficiary information is reviewed:

- Date of birth/age
- Date of death
- Citizenship status
- City/zip code if needed to determine managed care status
- County of residence
- Sex/gender
- Beneficiary ID
- Living arrangements (home, institution, group home, other)
- Patient liability
- Patient level of care, if applicable
- Program eligibility and effective dates (relative to dates of service).
- Beneficiary residency requirement for enrolling in managed care plan/ or living in a mandatory managed care geographical area

B. Health Plan Contracts

In order to determine that the capitation paid was correct, the contractor reviews the terms of the health plan contract to determine the following:

- Capitation rates in effect for coverage month
- Terms of the contract regarding pro-ration of capitation for births and deaths
- Population and service carve-outs
- Reinsurance or stop loss terms, if applicable
- Geographic service areas covered by each plan under contract
- Other contract terms that could affect proper payment

C. Correct Payment

The contractor will determine whether the beneficiary is in the correct rate cell based on state policies and the health plan contract and whether the proper payment was made based on that rate cell.

D. Other

The contractor will check for duplicate payments made for the same beneficiary for the same month and also document any adjustments made within 60 days of the sampled payment date.

60.3 - Data Processing Error Codes

DP 1 – Duplicate item: The sampled line item/claim or capitation payment is an exact duplicate of another line item/claim or capitation payment that was previously paid (for example, same patient, same provider or health plan, same date of service, same procedure code, and same modifier).

DP 2 – Non-covered service: The State policy indicates that the service is not payable by the Medicaid or CHIP programs and/or the beneficiary is not in the coverage category for that service.

DP 3 – FFS claim for a managed care service: The beneficiary is enrolled in a managed care organization that should have covered the service, but the sampled service was inappropriately paid by the Medicaid or CHIP FFS component.

DP 4 – Third-party liability: The service should have been paid by a third party and was inappropriately paid by Medicaid or CHIP.

DP 5 – Pricing error: Payment for the service does not correspond with the pricing schedule on file and in effect for the date of service.

DP 6 – Logic edit: A system edit was not in place based on policy or a system edit was in place but was not working correctly and the line item/claim was paid (for example, incompatibility between gender and procedure).

DP 7 – Data entry error: A line item/claim is in error due to clerical errors in the data entry of the claim.

DP 8 – Managed care rate cell error: The beneficiary was enrolled in managed care and payment was made, but for the wrong rate cell.

DP 9 – Managed care payment error: The beneficiary was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.

DP 10 – Administrative/other: A payment error was discovered during a data processing review but the error was not a DP1 – DP9 error.

DTD – Data Processing Technical Deficiency: A payment error was discovered during a data processing review by the error was not a DP1 – DP9 error.

70 - Medical Record Reviews

A medical review error is an error resulting in an overpayment or underpayment that is determined from a review of the provider's medical record or other documentation supporting the service(s) claimed, Code of Federal Regulations that are applicable to conditions of payment, the State's written policies, and a comparison between the documentation and written policies and the information presented on the claim.

The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with 42 CFR 440 to 484.55 of the Code of Federal Regulations that are applicable to conditions of payment and the State's documented policies, is the dollar measure of the payment error.

Medical review errors include, but are not limited to the following:

- Lack of documentation
- Insufficient documentation
- Procedure coding errors
- Diagnosis coding errors
- Unbundling

- Number of unit errors
- Medically unnecessary services
- Policy violations
- Administrative errors

Medical review is conducted on all sampled FFS claims, with the exception of Medicare Part A and Part B premiums, primary care case management payments, denied claims, and zero-paid claims.

Medical review may be required for denied claims if the claim was denied for medical necessity or other reason verifiable only through review of the medical record. The medical review is exclusive of the data processing review.

Please see Attachment 70-A for examples of medical review policy questions.

The user's guide for the website States can access to track medical review findings is included in Attachment 50-A.

70.1 - Basic Medical Review Components

The purpose of medical review is to determine if each sampled claim was paid correctly. This determination is made based on information in the medical record and the paid claim. Although in most cases individual line items will be sampled, it may be necessary to review all items on a claim in order to determine the accuracy of the individual line (reviewers will not record errors associated with lines on a claim that were not part of the sample).

The mechanics of the medical review (e.g., documentation that is requested, policies reviewed) will vary by service type. In general, review procedures will map closely to the PERM claim categories, although in some cases (e.g., denied claims), specific review procedures may be required. The PERM claim categories for medical review are listed below.

Claim Category 1: Inpatient Hospital (non-mental)

Claim Category 2: Inpatient Psychiatric, Mental Health, and Behavioral Health Services

- Inpatient and outpatient psychological, psychiatric and behavioral health services
- Drug and alcohol inpatient and outpatient services
- Group homes

Claim Category 3: Nursing Facility, Chronic Care Services, and Intermediate Care Facilities (ICF)

- Nursing home and convalescent centers
- Intermediate Care Facilities (ICF)
- Chronic care hospitals

Claim Category 4: Intermediate Care Facilities (ICF) for the Mentally Retarded and ICF Group Homes

Claim Category 5: Outpatient Hospital Services and Clinics

- Outpatient hospital services
- Emergency room services (no inpatient admit)
- Clinic services

Claim Category 6: Physicians, Physician Clinics, and Other Licensed Practitioners' Services

- Physicians and other licensed practitioners' services
- Physician clinic services

Claim Category 7: Dental and Oral Surgery Services

Claim Category 8: Prescribed Drugs

Claim Category 9: Home Health Services

- Home health agency services
- Medical supplies, equipment and appliances through the Agency

Claim Category 10: Personal Support Services

- Personal care services
- Personal care attendant, aide, homemaker services and respite care
- Targeted Case Management services
- Private Duty Nursing
- Midwife/nurse midwife
- Meal delivery services

Claim Category 11: Hospice Services

- Services provided in the home or in a nursing facility, hospital, or hospice facility

Claim Category 12: Therapies, Hearing and Rehabilitation Services

- Therapies: physical, occupational and respiratory
- Services for speech, hearing and language disorders
- Necessary supplies and equipment

Claim Category 13: Day Habilitation and Waiver Programs, Adult Day Care, and Foster Care

- Day habilitation programs, waiver programs
- Adult day care and foster care

Claim Category 14: Laboratory, X-ray and Imaging Services

Claim Category 15: Vision: Ophthalmology, Optometry and Optical Services

Claim Category 16: Durable Medical Equipment (DME) and supplies, Prosthetic/Orthopedic devices, and Environmental Modifications

- Prosthetic and orthopedic devices
- Other medical supplies/equipment
- Environmental modifications

Claim Category 17: Transportation and Accommodations

Claim Category 99: Unknown

For review guidance of each claim category, please see Attachment 70-B.

70.2 - Process for Conducting the Medical Review

A comprehensive medical review will be performed on each sampled unit (full claim or line item) for which medical records are received. This review includes reviewing medical record documentation, reviewing State-specific guidelines and policies related to the claim, and determining whether the service was medically necessary, reasonable, provided in the appropriate setting, billed correctly, and coded accurately.

Claims will be reviewed for medical errors using the PERM review process in accordance with State specific policies (i.e., if a certain aspect of the recommended review process outlined here does not apply in a given State, then it does not have to be followed). The

reviewer is responsible for using all applicable documents, references, medical necessity guidelines and their clinical review judgment to determine if the service was medically necessary and paid in accordance with required policies.

Medical review is considered complete when 100 percent of the amount paid is found to be in error. No further review is necessary. The RC system will populate either the nurse or coder findings automatically to mirror the original findings when 100 percent error has been recorded by the other component.

A. Verification of Documentation Sufficiency

In order for the CMS contractor to determine whether appropriate and sufficient documentation was received, the following information is evaluated:

- Was all documentation received to support the service billed in accordance with State Policy documentation requirements?
- Does documentation support the requested sampling unit?
- Does documentation support the dates of service?
- Are signed physician orders included?
- Are approved certifications/re-certifications included (if required by State policy)?

The original medical record request lists the specific supporting documentation that should be sent for each claim category.

B. Verification of Service Provision in Accordance with State Policy

The policy review includes review of the applicable State-specific Medicaid or CHIP policy related to the service that is under review. The procedure or service documented in the medical record is reviewed to determine if the service is a covered service under the State's policy and to determine if there are any service limitations applicable to the covered service (e.g., units, quantities) and if the service was provided within those limitations. Source documentation for the review will include documented State policies, including non-covered benefit limitations, provider manuals, and the Code of Federal Regulations.

C. Confirmation of Medical Necessity of Service

The medical necessity review includes review of the medical record to determine if the service provided was consistent with the symptoms or diagnosis under treatment. In addition, the medical review may also involve a contextual claim review of other services provided to determine the pattern and feasibility of the service being reviewed. The reviewer may need to review the entire medical record to determine if the sampled service was medically necessary.

Source documentation for the review will include documented State policies, including medical necessity documentation guidelines utilized by State (e.g., McKesson InterQual, Milliman Care Guidelines, or internal State guidelines), provider manuals, and the Code of Federal Regulations.

D. Determination of Whether the Service Rendered Matches the Service Codes Billed and Paid

The coding validation of the medical review may involve confirmation of the diagnosis recorded by the provider and its relevance to the billed procedure code. The coding review includes reading the medical record documentation and applying applicable coding guidelines to assure that the code billed and paid is the most appropriate code and level of code for the service rendered and that multiple codes were not assigned when only one code is appropriate (unbundling). For long-term care and prescribed drugs claim categories, coding reviews are not performed.

In order for the CMS contractor to determine whether appropriate and sufficient documentation was received, the following information is evaluated:

- Does the code billed agree with documentation in the medical record?
- Would another procedure code be more appropriate?
- Are procedure codes unbundled? Does billed code agree with diagnosis?
- Is diagnosis code appropriate (if relevant to payment)?
- Is diagnosis included in DRG (if relevant to payment)?

E. Verification of Appropriate Physician Certification

For long-term care, inpatient hospital services, and home health care, the review determines whether there was a signed physician certification, if required by State policy.

70.3 - Special Rules for Medical Review

A. Underpayments

If reviewers note a discrepancy between the number of units billed and the number of units provided, they should verify whether there is a written State policy in effect at the time the payment was made for reimbursing only the amount billed up to the maximum allowable amount, and cite no error if there is a policy, or cite an error if there is no policy.

B. Date of Service

Claims with incorrect date of service (DOS) are medical technical deficiencies (MTD) if all of the following apply:

- If all the other details of the claim are correct (the medical record matches the claims details)

- If the DOS do not deviate by more than seven calendar days (the medical record shows the DOS is no more than seven calendar days before or after the billed DOS)

- The medical record supports the charges billed

- For per diem hospital claims, the record reflects the same number of days as was billed and rate schedules remain the same

These claims should be coded MTD with $0.00 in error.

Claims with incorrect DOS are payment errors if all of the following apply:

- Other details of the claim are incorrect (the medical record does not match the claims details)

- The DOS deviates by more than seven calendar days (the medical record shows the DOS are more than seven calendar days before or after the billed DOS)

- The medical record does not support the charges billed (e.g., procedure/treatment not performed but billed, wrong number of units billed)

These claims should be coded with the appropriate medical review error code and with the appropriate payment amount in error.

For home and community based services, services are often provided on a daily basis, therefore, claims with incorrect DOS are payment errors if all of the following apply:

- The DOS do not match the claim

- The medical record does not support the charges billed (e.g., procedure/treatment not performed but billed, wrong number of units billed)

These claims should be coded with the appropriate medical review error code and with the appropriate payment amount in error.

C. Level of Care

If the medical review indicates the beneficiary did not meet medical necessity for inpatient hospitalization because the care could have been provided and billed at an outpatient observation level, instead of viewing the total claim amount as an error, credit the State for the appropriate charges for outpatient observation, by re-pricing the claim (see Section 90.2 for additional detail). When a State's Medicaid program does not cover observation status, and outpatient observation level of care was medically necessary, no finding of improper payment is made.

70.4 - Medical Review Error Codes

MR 1 – No documentation: The provider did not respond to the request for records within the required timeframe.

MR 2 – Insufficient documentation: There is not enough documentation to support the service.

MR 3 – Procedure coding error: The procedure was performed but billed using an incorrect procedure code and the result affected the payment amount.

MR 4 – Diagnosis coding error: According to the medical record, the diagnosis was incorrect and resulted in a payment error – as in a Diagnosis Related Group (DRG) error.

MR 5 – Unbundling: The provider separately billed and was paid for the separate components of a procedure code when only one inclusive procedure code should have been billed and paid.

MR 6 – Number of unit(s) error: The incorrect number of units was billed for a particular procedure/service, National Drug Code (NDC) units, or revenue code. This does not include claims where the provider billed for less than the allowable amount, as provided for in written State policy.

MR 7 – Medically unnecessary service: The service was medically unnecessary based upon the documentation of the patient's condition in the medical record in accordance with written State policies and procedures related to medical necessity.

MR 8 – Policy violation: A policy is in place regarding the service or procedure performed and medical review indicates that the service or procedure is not in agreement with the documented policy.

MR 9 – Administrative/other medical review error: A payment error was determined by the medical review but does not fit into one of the other medical review error categories, including State-specific, non-covered services.

MTD – Medical Technical Deficiency: A deficiency was found during medical review that did not result in a payment error.

In some cases, it may be difficult to distinguish between insufficient documentation errors (MR 2) and policy violation errors (MR 8). Exhibit 6 outlines examples of the guidelines the RC will follow to assign these errors properly and consistently.

Exhibit 6. Assignment of MR 2 and MR 8 Errors

Error Code	Qualifier (1)	Qualifier (2)	Qualifier (3)
MR 2 – Insufficient Documentation Error	Provider did not supply sufficient documentation to support medical necessity of the claim.	Provider did not supply a valid prescription	Medical records do not contain the daily documentation of tasks performed on DOS billed
MR 8 – Policy Violation	Documentation does not meet State policy requirements for conditions of payment for the service or procedure performed	Prescription refill occurred beyond one year from the date of issuance of the original	Documentation of the home delivered meal services does not meet the State requirements for conditions of payment.

80 - Eligibility Reviews

An eligibility error occurs when a person is not eligible for the program or for a specific service and a payment for the sampled service or a capitation payment covering the date of service has been made. These policies apply to reviews conducted under PERM; MEQC rules may differ.

80.1 - Eligibility Reviews

A. 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. There is no administrative period for the PERM eligibility reviews.[5]

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.

[5] 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 for because PERM cases are reviewed as of the State's most recent action.

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).

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 administered when the case was previously sampled.

B. 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, and 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.

C. Verification Standards

The purpose of the eligibility review is to verify the eligibility of sampled cases using State eligibility criteria in effect at the time of the decision under review (so long as the criteria comply with the State plan 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 SMM, 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 SMM.

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.

1. Required PERM Verification

Verification and verified information must be present in the case record and current (not more than 12 months old, except when citizenship is appropriately verified). 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 (i.e., residency, bank accounts, household composition, earned income and unearned income), they must be independently verified using the verification standards below in Section 80.F (Process for Verifying Active Case Eligibility).

2. Acceptable Documentation

The agency must examine the evidence in the case record and independently verify elements of eligibility where evidence is: (1) missing or (2) outdated and likely to change. Outdated evidence is evidence that is older than 12 months prior to the sample month. Exhibit 8 lists examples of categorical and financial criteria.

Exhibit 8. Examples of Categorical and Financial Eligibility Criteria

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

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 that eligibility is being verified;
- Caseworker notes in reasonable instances:
    - To verify residency: “Visit to Susie Jones at assisted living home. Ms. Jones is residing there.”

- To verify household composition: "Visit to John Jackson's residence at 1234 Summerville Court. Mr. Jackson, his wife Nancy and son John Jr. live in the home."
- To verify income: "Conducted a home visit and verified Bank of America statement for checking account #12345, dated March 2011, with an ending balance of $55.07 and no unusual deposits or withdrawals other than the Social Security benefit of $700";

- Permanent documents (e.g., birth certificate, 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 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.

3. Acceptable Self Declaration

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

Some States also accept a signed statement for other categorical and financial criteria as long as there is no Federal requirement to document the information, such as the Deficit Reduction Act of 2005 requirement to document citizenship for Medicaid. The CHIPRA allows for States to verify citizenship for children enrolled in Medicaid and CHIP through the SSA.[6]

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 must be in accordance with official written State policy and the attestation must be:

- Not older than 12 months prior to the sample month;
- In a 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.

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

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[6] 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.

that 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 cannot be obtained and eligibility cannot be verified through other reasonable evidence, cite the sampled case as "Undetermined."

D. Simplified Enrollment and Passive Renewal for Applications and Redeterminations

For Medicaid, the eligibility worker is required to check the Income and Eligibility Verification System (IEVS) (Section 1137 of the Social Security Act and 42 CFR 435.940 through .965) to confirm the income of an applicant during the processing of an application or renewal. For CHIP, States are required to perform screen-and-enroll procedures which may include a full Medicaid review of income eligibility if a child or family is considered potentially eligible for Medicaid after the screening.

Passive renewal for which a client's circumstances are self-declared are acceptable when:

- The processes are consistent with the State's written policies and procedures; and
- The client circumstances are documented in the case record and can be substantiated for the PERM review.

This includes, but is not limited to:

- The PERM reviewer obtains caseworker notes that describes the process used for verifying income eligibility using IEVS, and uses the IEVS information for the PERM review decision;
- The PERM reviewer obtains caseworker notes that describe the process and results for screen and enroll procedures for Medicaid, and the Medicaid verification is used to substantiate the PERM review decision;
- The PERM reviewer obtains Medicaid documentation from a full Medicaid review conducted before an applicant was enrolled into CHIP, and the Medicaid documentation is used for the PERM review decision; or
- The PERM reviewer obtains and documents caseworker notes of the process used to verify a passive renewal redetermination, documenting case circumstances in which the case was being continued for eligibility, and uses this information for the PERM review decision.

E. PERM Technical Errors

PERM technical errors are errors that would not result in an improper payment. 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 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.

F. 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 within 12 months of the sample month, the last action month is the review month to be used to verify eligibility. If the last action was taken more than12 months before the sample month, verify eligibility as of the sample month (see exception for continuous eligibility policies in Attachment 80-A Process for Conducting Medicaid and CHIP Active Case Reviews: Other Review Situations).

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 for Medicaid and ineligible, 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 80.1.E. If the case is ineligible for the eligibility category in which the case is enrolled, determine 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:

E – Eligible: A case meets the State's categorical and financial criteria for receipt of benefits under the program

NE – Not eligible:[7] 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

[7] For family applications, if sampling at the application level or family level, if one individual in the family unit is identified as ineligible, then the case will be considered not eligible. However, the dollars in error will be identified as only those dollars associated with the individual in the family who is ineligible. 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 (for MEQC), we believe that it is appropriate to call a case "not eligible" for the purpose of calculating the case error rate.

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

MCE 2 – 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

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 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 these 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: 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. See Attachment 80-A, Instructions for Conducting Medicaid and CHIP Cases: Other Review Situations.

G. Process for Conducting Medicaid and CHIP Negative Case Reviews

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.

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 80.1.E, Acceptable Documentation or Section 7269 of the SMM.

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.

Cite the case "Improper denial" or "Improper termination" if no evidence exists to support the denial or termination.

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.

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.

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."

80.2 - Payment Reviews

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 these cases (including both eligible cases and cases with eligibility errors) will form the basis of the dollar-weighted error rate.

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 9) illustrates the timeframe for collecting 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 60 days), the total dollars collected for the sampled case would reflect the adjusted amount for the service received in October.

Exhibit 9. 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

A. Instructions for Conducting Medicaid and CHIP Payment Reviews

The payment review process, which is identical for Medicaid and CHIP, is described below. Information on certain unusual situations is provided in Attachment 80-B Payment Reviews for Active Medicaid and CHIP Cases: Other Review Situations). 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 four 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 is eligible for the services received. Payments for services for which the beneficiary is not eligible to receive are considered improper and are included in the error rate calculation.

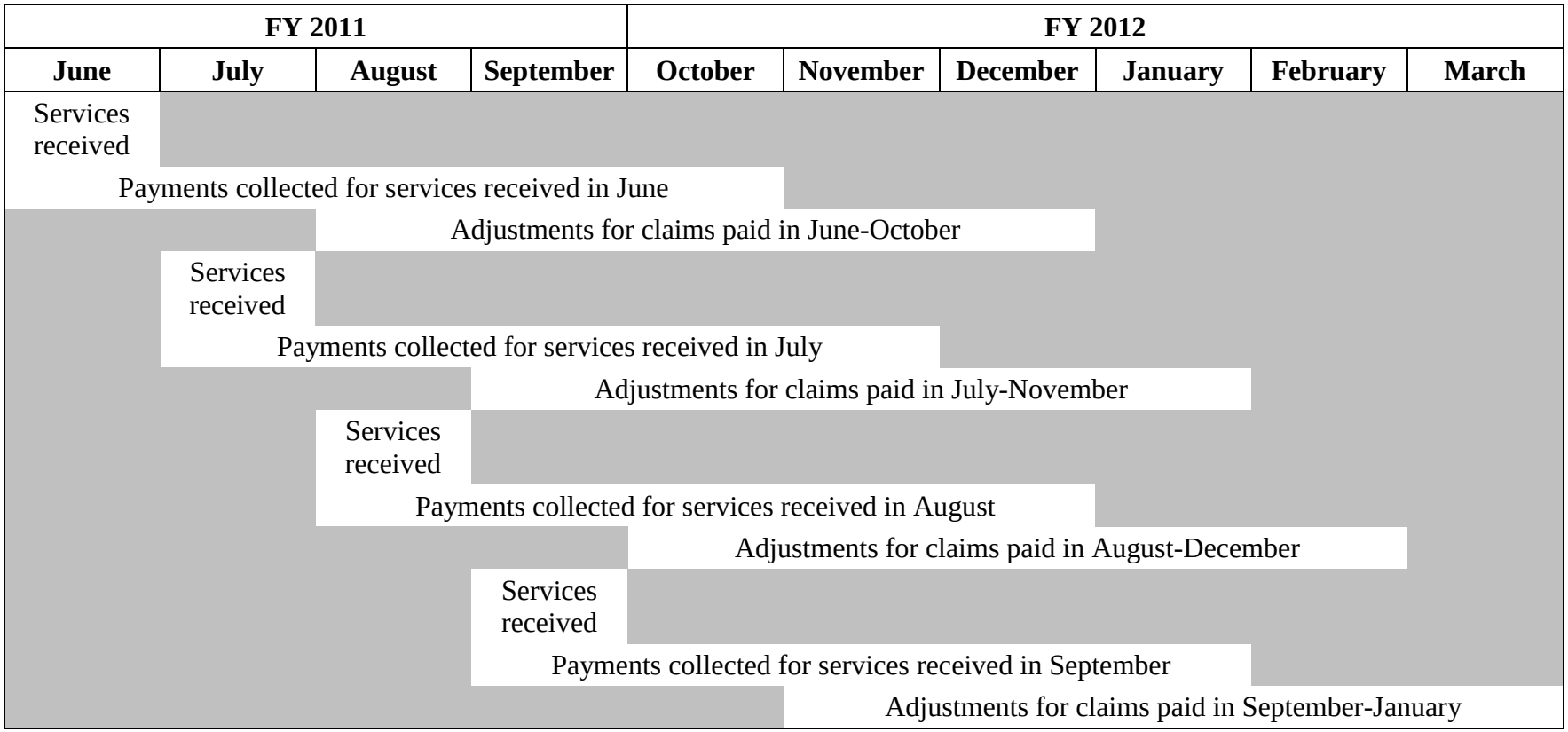
Step 4: Record the amount of correct payments and the amount of dollars in error, if any. States must be able to separately identify overpayments or underpayments in accordance with the eligibility review finding. Note that depending on the results of the payment review, the eligibility review finding could change, e.g., a case is cited "Eligible" for the active case eligibility review, but upon collecting 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 10 below).

Exhibit 10. Five Month Payment Collection Falling Outside the Fiscal Year



80.3 - Eligibility Reporting

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

- On the 1st day of August prior to the Federal fiscal year in which a State is being measured for PERM, a Medicaid sampling plan and a CHIP sampling plan;
- On the 15th day of the month following each sample month (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;
- On the last day of the 5th month after the sample month, the detailed eligibility findings for active and negative;
- On the 15th of the 7th month after the sample month, 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 Attachment 80-D, Eligibility Reporting Due Dates, 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.

Please see Attachment 80-E for sample reporting forms. All required forms should be submitted through the eligibility review reporting website. See Attachment 80-C for a user guide to the eligibility review reporting website.

90 - Difference Resolution and Appeals

90.1 - Difference Resolution Process

The difference resolution process is the means by which a State can dispute the CMS contractor's medical and data processing error findings and present evidence to support the State's belief that the claim was correctly paid.

If an error is identified that affected payment, the State is notified and given an opportunity to review the documentation associated with the payment and dispute the error finding (with the exception of errors due to "no documentation"). If unsatisfied with the difference resolution decision, States could appeal the error finding to CMS. There is no dollar threshold to meet for requesting appeals from CMS.

Errors that were not challenged by the States or upheld following the difference resolution and appeal process are included in the error rate calculation. If an error was found in both the data processing review and medical review for a specific claim, the total error amount reported does not exceed the total paid amount for the claim.

The CMS contractor will post sampling unit disposition reports of claims review findings on its website on the 15th and 30th of each month for States to review and determine whether they agree with the error determinations. The State can file a notice that it disagrees with the error findings and provide supporting evidence that the claim was correctly paid. The CMS contractor will re-review the claim together with the State's documentation and either reverse or uphold its findings.

A. Disposition Reports

Disposition reports contain information on the CMS contractor's findings of the data processing and medical reviews of the FFS claims and the data processing review findings of the managed care claims. The CMS contractor will post State-specific disposition reports for each State being measured in the relevant fiscal year on its website. Details on the website location will be provided by the CMS contractor.

The CMS contractor will post sampling unit disposition reports of claims review findings on its website on the 15th and 30th of each month during the review cycle. States will be notified via e-mail when a disposition report is available for viewing. The website is confidential and designed so that States do not have access to other States' information.

The disposition report will contain the findings on the data processing and medical reviews. States can choose to dispute both the data processing review error findings and the medical review error findings. Most likely, the majority of the findings on the data processing reviews will be posted before the majority of the medical reviews because the processing reviews are conducted once the State's data are received by the RC, whereas the medical reviews are conducted on a flow basis as the medical records are submitted by providers.

Since the data processing and medical reviews are conducted independently, the initial error amounts will be determined separately for purposes of the difference resolution. However, it is possible that a claim can have both a data processing error and a medical review error. When final findings are reported to the CMS contractor, all error amounts per claim will be taken into consideration but the total error amount on any claim will not exceed the total paid amount.

The disposition report will detail the CMS contractor's findings for each claim reviewed in the previous month as follows:

- The claim identifying information (i.e. assigned control number);
- Data processing review determination findings;
- Medical review determination findings, (for FFS claims);
- Correct paid amount or improper paid amount of an error; and,
- Reason for error, as applicable.

Simultaneous to the release of the sampling unit disposition report, the CMS contractor will provide a password-protected compact disc (CD) to each State that contains the medical records associated with the FFS claims cited with medical review errors. A State can use the medical

records to evaluate whether it agrees with the CMS contractor's finding or file a notice of difference in finding.

B. State Process to File a Notice of Difference in Finding

If a State disagrees with an error finding, it should file a Notice of Difference in Finding on the CMS contractor's web site within 20 business days from the posting date of the disposition report for the claim. The State's request will be dated and recorded in the website to validate that the request was made within 20 business days of the posted disposition report. Be advised that notices filed after the 20 business day timeframe will not be included or considered in the difference resolution process. Therefore, we recommend that every State designate a secondary State person as back-up to the primary State person responsible for tracking/monitoring/responding to error findings for each program so that each State will be able to respond to the findings in the event the primary person is unavailable.

Under extraordinary circumstances that cause a delay of at least 5 business days of the 20 business day period for a State to determine whether to rebut the error finding, the State may request to have a new 20 day timeframe for filing the Notice of Difference in Finding. The State has to initiate the request in such circumstances within 3 business days from the date of the error posting on the disposition report. The request should be made to CMS; the contact information is available on the CMS PERM website at: http://www.cms.hhs.gov/PERM.

An example of extraordinary circumstance would be when the CD containing the medical records being delivered to the State was delayed due to air traffic control problems.

The State may file a Notice of Difference in Finding for the following reasons:

> A claim has a medical review related error (coded as MR 2 through MR 9 as defined in the Section 70.4, Medical Review Error Codes) or a data processing related error (coded DP 1 through DP 10 as defined in Section 60.3, Data Processing Error Codes); or a deficiency has been identified during the data processing review (DTD) or medical review (MTD) that did not result in a payment error.

When the above conditions are met, the State may file a Notice of Difference in Finding based on evidence that one or more of the following occurred:

- A policy was applied in error
- A policy that was in effect at the time of service was not considered during the review (includes updates to current policies but excludes new policies developed after the end of the quarter under review and made effective retroactive to the quarter)
- The error finding was not justified by the evidence provided to the reviewer
- The claim is in error but the payment amount in error is overstated or understated
- The State can demonstrate that the claim should only have been subject to a data processing review rather than a medical review

- The State can demonstrate that the claim was for a managed care enrollee and not eligible for a medical review

- The State can demonstrate that the claim was erroneously included in the universe and/or sample, e.g., the claim was paid with 100 percent State funds

When filing a Notice of Difference in Finding, the State will need to provide:

- The reason why the State believes the claim was correctly paid; and
- The factual basis, substantiated by valid and convincing written evidence, supporting the reason why the claim was correctly paid. Valid and convincing written evidence is information that was contained or should have been contained in the medical records at the time of the review, policies in effect at the time of service (including updates to current policies but excluding policies developed after the end of the quarter under review and made effective retroactive to the quarter) or evidence that the claim should not have been subjected to a medical review. Evidence must be limited to no more than 5 pages of written documentation, including links to websites or other references to sources, to ensure that excessive time is not spent reviewing voluminous documentation. Evidence exceeding this limitation will not be considered in the final evaluation. All evidence containing PHI should not be included on the website. Instead, documents containing PHI should be submitted to the RC using the designated PERM secure fax number.

The State may not file a Notice of Difference in Finding based upon:

- Adjustments made to claims outside of 60 days from adjudication. The difference resolution process is not intended to extend the 60-day timeframe for adjustments. Therefore, subsequent adjustments to claims will not be considered as a valid reason to reverse findings on claims.

- Claims with findings of "no documentation" (MR 1) errors due to providers not submitting the requested information within the timeframe allowed. States can follow-up with providers during the collection of medical records to ensure providers submit the necessary documentation within the allowed timeframe.

- Operating State policies that are unwritten or conflict with the State's plan or Federal rules.

- Policies developed after the end of the quarter under review and made effective retroactive to the quarter.

Requests for difference resolutions that do not adhere to the criteria set forth in this section will not be considered.

C. Determination of Error Finding

The CMS contractor will review the State's reason(s) for the difference in finding together with the evidence submitted and render a final determination within 15 business days from the date that the State's notice was filed. The State can access the CMS contractor's website to view the posted determination.

If the CMS contractor agrees with the State that the claim was properly paid, the error finding will be reversed. If the CMS contractor upholds its error determination, the State may request reconsideration from the CMS contractor if there are compelling reasons. For example, there are two identical errors, but one decision is reversed while the other is upheld. Requests for reconsideration of errors without a compelling reason will not be granted. The reconsideration of errors is at the CMS contractor's discretion.

90.2 - Repricing

During medical reviews, claims are reviewed for accuracy of payment. In some cases, an error may be made (e.g., coding error, number of units error) that would result in only a portion of the payment being in error. In these cases, the claim must be "repriced" so that the difference between what was paid and what should have been paid (the error amount, for PERM purposes) can be calculated.

Types of errors that may partially affect payment include:

- MR 3 - Procedure coding error
- MR 4 - Diagnosis coding error
- MR 5 - Unbundling
- MR 6 - Incorrect number of units billed
- MR 9 - Other

As required under 42 CFR § 431.970(a)(6), States are obliged to report re-pricing information on claims that were determined during the review to have been improperly paid. In the past, the CMS Review Contractor (RC) has asked States to re-price claims determined during the review period that have been improperly paid, in order to verify the accuracy of the improper payment. However, if a State inadvertently re-prices claims incorrectly, it can affect the accuracy of the measurement. Therefore, States must verify the accuracy of the re-priced claims.

When re-pricing a sampling unit, the RC first determines the total value of a sampling unit (i.e., the amount of money paid for the service that was reviewed). If the sampling unit was in error, the RC determines the initial dollar value of the error as 100% of the paid amount.

States have the opportunity to re-price claims with partial errors during the difference resolution process. When a State re-prices a claim, the State must provide documentation verifying the accuracy of the re-pricing, such as rate schedules or screen shots. If the documentation is not

provided during difference resolution or if the State does not request a difference resolution, the full amount of the claim will remain as the error amount.

When the State supplies the re-priced amount, then the amount in error is calculated by taking the amount paid minus the amount that should have been paid. If the result is a positive number (less should have been paid), then the amount in error is an overpayment. If the result is a negative number (more should have been paid), then the amount in error is an underpayment. If the State does not provide a re-priced amount, then the error will be 100 percent of the paid amount for that sampling unit.

90.3 - Claims Appeals Process

A. State Appeal to CMS

States may appeal to CMS error findings upheld by the CMS contractor at difference resolution on any claim where an error or deficiency was identified. States have the opportunity to submit additional written evidence to the RC to submit their appeal requests. The RC will provide all documentation on each PERM claim appealed to CMS for their review and consideration.

B. Impact on State Error Rate

If the State does not file a Notice of Difference in Finding within 20 business days from the posting date of the disposition report, the CMS contractor's finding will be submitted for inclusion in the State's error rate.

It is possible that Notices of Difference in Finding that States file based upon disposition reports posted after the second April in the production cycle may not be resolved prior to the July 15 cut-off date for reviews; which is necessary to commence the error rate calculation. All differences in findings between the State and the CMS contractor not resolved by July 15 will be considered improper payments and included in the error rate calculation. All appeals to CMS that have not been finalized as of July 15 will also be considered improper payments for purposes of the error rate calculation.

States may appeal the CMS contractor's determinations to CMS through the CMS contractor's website within 10 business days from the date of the findings as a result of the difference resolution is posted. The State's reasons for difference resolution and the CMS contractor's justification for upholding its initial error finding already will be available to CMS on the CMS contractor's website. CMS will make the final determination on the sampled claim appealed and post notice its findings on the CMS contractor's website within 30 days of the State's request for appeal. The CMS contractor will send an email to the State to access the CMS contractor's web site to view CMS' decision on the appeal. There will be no further judicial or administrative review of CMS' decision; the CMS decision is final.

90.4 - 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. If CMS' decision causes an erroneous payment finding to be made, any resulting recoveries will be governed by §431.1002.

100 - Errors and Error Rate Calculation

In determining a PERM error rate, at the individual State level, at the national level, and for any program, the methodology is identical: the PERM error rate is the ratio of estimated improper payments to estimated total payments.

Improper payments are determined by the appropriate medical, data processing, and eligibility reviews, and are simply the absolute dollar value of the improper payment. An improper payment is generally the difference between what *was* paid and what *should have been* paid.

"Estimated" payments are used in the calculation because only a sample of payments or cases are reviewed. Because the total improper payments and total payments are estimated by extrapolating the sample errors and sample payments to the universe based on the appropriate sampling frequencies, we use the term "estimated" to describe the extrapolated figures.

100.1 - Error Codes

See Exhibit 11 below for a summary of error codes for medical review, data processing review, and eligibility review.

Exhibit 11. PERM Error Codes

Medical Review Error Codes		Data Processing Review Error Codes		Eligibility Review Error Codes	
C	Correct	*C*	Correct	*E*	Eligible
MR 1	No documentation	*DP 1*	Duplicate item	*NE*	Not eligible
MR 2	Insufficient documentation	*DP 2*	Non-covered service	*EI*	Eligible with ineligible services
MR 3	Procedure coding error	*DP 3*	FFS claim for a managed care service	*U*	Undetermined
MR 4	Diagnosis coding error	*DP 4*	Third-party liability	*L/O*	Liability overstated
MR 5	Unbundling	*DP 5*	Pricing error	*L/U*	Liability understated
MR 6	Number of unit(s) error	*DP 6*	Logic edit	*MCE 1*	Managed care error 1
MR 7	Medically unnecessary service	*DP 7*	Data entry error	*MCE 2*	Managed care error 2
MR 8	Policy violation	*DP 8*	Managed care rate cell error		
MR 9	Administrative/other medical review error	*DP 9*	Managed care payment error		
MTD	Medical review technical deficiency	*DP 10*	Administrative/other		
		DTD	Data processing technical deficiency		

100.1.1- Error Hierarchy

When errors are found to be 100 percent in error under medical review, a hierarchy is used to classify the final error code used for reporting. This hierarchy is applied to identify the one error code that is most responsible for the incorrect payment, since the total amount in error cannot exceed the paid amount. The following lists the error codes in priority order:

MR 1 - No documentation submitted by provider. When notified that no record was submitted by the provider, the system will code the review findings as MR 1 in both the coding and nurse tables. This sampling unit would not be submitted for medical review. The amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit and recorded as an overpayment. No Difference Resolution or Appeal can be filed on these sampling units. Re-pricing request from the State is not needed for these sampling units.

MR 2 – Insufficient documentation. If additional documentation is requested from the provider through the DDC by the nurse or coder, both sampling units will be marked by the system as pending additional documentation. If the provider does not supply it within 15 days, the sampling unit will be considered as 100 percent in error. If additional documentation was not received within the 15 days, the RC system will populate the findings as MR 2 in both the coding and nurse tables. The amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit and an overpayment. If some additional documentation is submitted timely but after review is still considered not sufficient, either the nurse or coder will code the findings as MR 2, and the other (nurse or coder) findings screen will be populated by the system as MR 2 and the review will be eliminated from the remaining workload queue. The system will populate the amount in error as 100 percent of the amount paid and an overpayment. Re-pricing request from the State is not needed for these sampling units.

MR 8 – Policy violation. If the nurse or coder finds that the services provided were not in accordance with the State's policies, the sampling unit will be coded as a MR 8. Then the other (nurse or coder) screen will be coded a MR 8 by the system and the claim will be removed from the workload queue. 100 percent of the amount paid will be coded by the system as the amount in error and an overpayment in both the nurse and coding tables. Re-pricing from the State is not needed for these sampling units.

MR 7 – Not medically necessary. If the nurse finds that the sampling unit was not medically necessary, they will code the findings as MR 7. The findings table for the coder will also be populated by the system with MR 7. The amount in error will be populated by the system with 100 percent of the amount paid and as an overpayment in both the coding and nurse tables in most circumstances. The sampling unit will be removed from further review. If the State does cover observation level of care and the hospital stay is not medically necessary, the MR7 may be a partial error. Under these conditions, re-pricing by the State may be necessary.

100.1.2- Multiple Errors on One Claim

The RC will reconcile all claims where more than one error has been identified under medical review before reporting the error to the State. The error code that is 100 percent in error (i.e., the greatest amount in error) will be selected and errors with partial error amounts on the same claim will be ignored. PERM error amounts cannot exceed the total paid amount of the claim.

100.2 - Adjustments

As noted earlier, the dollar amount of error for PERM purposes is generally the difference between what *was* paid and what *should have been* paid. PERM uses the original paid date and

original paid amount to determine what was paid, with the exception of any adjustments made within 60 days of the original paid date.

Adjustments made outside of the 60-day timeframe allowed under PERM are not considered in determining whether a payment error should be cited. The reviewer will determine if the payment was made correctly based on the policies in effect at the time of the payment and the State's compliance with its payment policies. That is, the reviewer compares the payment amount to the amount that should have been paid at the time payment was made. For example, if prices are changed retroactively but the changes are made outside of the 60-day adjustment timeframe, it is not an error *if the payment made was based on the pricing schedule on file at the time payment was made*. Thus, if a payment was made and then adjusted more than 60 days later because of a State-initiated adjustment that was required for programmatic reasons that are unrelated to payment errors, it should not be considered an error in the PERM review.

100.3 - Claims Error Rate Calculation

CMS will calculate the claims error rates for each program. CMS will provide an error rate calculator for States to use, as well as offer assistance from the SC to explain State-specific error rates. However, the SC will calculate the official error rates for each State. A total of three error rates will be calculated for Medicaid and CHIP.

- A FFS payment error rate
- A managed care payment error rate
- A combined FFS and managed care payment error rate (dollar weighted).

100.3- Eligibility Error Rate Calculation

CMS will calculate the eligibility error rates for each program. States may still calculate their own eligibility error rates using the formulas in Attachment 100-A. CMS will provide an error rate calculator for States to use, as well as offer assistance from the SC to explain State-specific error rates. However, the SC 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 according to:

- Payment error rate, which is dollar weighted; and
- Case error rate.

For negative cases:

- 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.

100.4 - State-Level Error Rate Calculation

Most of the States participating in PERM have six separate components: Medicaid fee-for-service (FFS); Medicaid managed care; Medicaid eligibility; CHIP FFS; CHIP managed care; and CHIP Eligibility. Each component has its own universe (and sample) that is being measured. Because the payment components (FFS and managed care) utilize independent universes, the payment error rates are additive. Because the eligibility component does not utilize an independent universe, a correction factor is applied to estimate the total program error rate, under the assumption that eligibility errors are independent of the other types of errors.

The State-level error rate is estimated as:

$$\hat{R}_i = \frac{\hat{t}_{e_i}}{\hat{t}_{p_i}}$$

In the equation, $\hat{R}_i$ is the estimated error rate for State i; $\hat{t}_{e_i}$ is the estimated dollars in error projected for State i and $\hat{t}_{p_i}$ is the estimated total payments for State i. Then,

$$\hat{t}_{e_i} = \sum_{j=1}^{8} \frac{M_{i,j}}{m_{i,j}} E_{i,j}$$

and

$$\hat{t}_{p_i} = \sum_{j=1}^{8} \frac{M_{i,j}}{m_{i,j}} P_{i,j}$$

In these equations, $M_{i,j}$ is the number of items in the universe for State i in strata j and $m_{i,j}$ is the number of items in the sample for State I in stratum j. The ratio of items in the universe to items in the sample is the inverse of the sampling frequency. Dollars in error in the sample for stratum j and State i, denoted $E_{i,j}$, is weighted by the inverse of the sampling frequency to estimate dollars in error in the universe for that stratum.

For example, if there are 10,000 items in the universe in stratum j, and the sample size in j is 100 items, the weight for the dollars in error in the stratum j sample is 100 (or 10,000/100). The estimated total dollars in error are then added across each of the eight strata to obtain total dollars in error for the universe. Total payments are estimated in the same way, where $P_{i,j}$ j is the total payments in the sample in stratum j for State i.

A. Combining Claims Review Error Rates across Program Areas

Combining the claims review error rates, i.e., combining the FFS and managed care error rate for Medicaid and the FFS and managed care error rate for CHIP, is relatively straightforward given that population payments are known. Note that CMS does not utilize true population payments in

calculating State rates for each program area. The reason for this is two-fold. First, the combined ratio estimator used allows for correction in possible bias if the sampled average payment amount differs from the universe average payment amount. However, if CMS utilized a combined ratio estimator to combine the program areas at the State-level, one program area that realized high sample average payment amount compared to the universe average would have too much influence in projections. For this reason, combining program area rates using the shares of expenditures as weights reduces the variance in the estimates from this source. Furthermore, following this method allows the same method for combining program area claims review rates at both the State and national level.

The following equations use the estimated State or national error rates and variances calculated in the previous two sections.

Let the overall claims review error rate for Medicaid or for CHIP can be defined as:

$$\hat{R}_C = \frac{t_{p_{FFS}} \hat{R}_{FFS} + t_{p_{MC}} \hat{R}_{MC} +}{t_p}$$

where

$$t_p = t_{p_{FFS}} + t_{p_{MC}} .$$

In this equations R is the error rate for FFS, managed care or combined (C), and t represents total payments for FFS, managed care, or the total, depending upon the subscript.

B. Eligibility Error Rate

Claims data were associated with each of the sampled eligibility cases in the active case strata. The dollar value of eligibility errors assessed was based on the implications of the eligibility review for the validity of the claims associated with the case. For each State, the results of review for each stratum were projected to the universe based on the sampling frequencies for that stratum, in a manner analogous to that described above for the FFS and managed care errors.

A national eligibility error rate was calculated using the same method employed in the FFS and managed care calculations. It is based on calculating an eligibility error rate for each of the four State strata, and combining these rates into an overall national rate based on the share of expenditures for the program in each stratum.

C. Combining Claims Error Rates and the Eligibility Error Rate

The claims rate and the eligibility rate are not mutually exclusive. Combining the two achieves a total, or combined, error rate which necessitates netting out the estimated overlap in projected error.

After combining the FFS and managed care components of each program into one overall claims error rate for Medicaid and one for CHIP, respectively, at the State and national levels, these

rates are combined with the respective eligibility error rates for each program. The combining of the claims review rate and the eligibility rate will be referred to as the combined error rate. The estimated combined error rate is given by:

$$\hat{R}_T = \hat{R}_C + \hat{R}_E - \hat{R}_E \hat{R}_C$$

where

$\hat{R}_T$ denotes the estimated Total, or Combined Error Rate

$\hat{R}_C$ denotes the estimated Claims Error Rate

and

$\hat{R}_E$ denotes the estimated Eligibility Error Rate

In practice, the fee-for-service (FFS) and managed care programs represent two distinct portions of the Medicaid universe. At both the State level and the national level, these rates for FFS and managed care can be combined using the "Separate Ratio Estimator" to produce an overall combined error rate for Medicaid.[8] This is referred as the claims rate.

The formula to compute the overall Medicaid claims rate (for State and national) is as follows:

$$\hat{R}_{Medicaid} = \frac{P_{MedicaidFFS}\hat{R}_{MedicaidFFS} + P_{MedicaidMC}\hat{R}_{MedicaidMC}}{P_{MedicaidFFS} + P_{MedicaidMC}} \qquad (1)$$
$$= S_{MedicaidFFS}\hat{R}_{MedicaidFFS} + S_{MedicaidMC}\hat{R}_{MedicaidMC}$$

where,

$P_{MedicaidX}$ = Payment for Medicaid 'X' program area (FFS or managed care)

$\hat{R}_{MedicaidX}$ = Estimated error rate for the Medicaid 'X' program area (FFS or managed care)

$S_{MedicaidX}$ = Share of payment for the Medicaid 'X' program area (FFS or managed care)

100.4.1- Process for Requesting Recalculation

A State may request a new error rate calculation from CMS based on resolution of outstanding differences when the expected impact of the change in the error rate is at least 0.25 percentage

[8] Cochran, W.G., Sampling Techniques. Third Edition. Wiley. 1977.

points. The request for recalculating the error rate must be made within 60 business days of the posting date of the State's program error rate on the CMS Review Contractor's website.

States may request resolution of unresolved error findings after August 30 and may request that CMS calculate a new error rate based on resolution of the outstanding differences. To request a recalculation of the error rate, the State must contact the SC in writing. The SC will advise States on this process.

When the outstanding differences are resolved, the RC will send a revised list of errors on which to recalculate the error rate. The SC will notify the State by e-mail of its revised error rate within 30 business days of receipt of the revised error list from the RC. A new State-specific sample size for any affected component will also be calculated based on the recalculated error rate.

100.5 - National Error Rate Calculation

To go from the error rates for individual States to a national error rate, two steps are taken. First, States were, themselves, divided into four stratum based on the size of the State. For each of the four strata, there were some States that were sampled, and some that were not. In this step, the error rate for the entire State stratum is projected from the error rates of the States that were sampled in the stratum. The method is analogous to the method for the estimated State-level error rates.

Let h represent the State strata, of which there are four, and n_h be the number of States sampled from stratum h. Then, the error rate for stratum h is given by:

$$\hat{R}_h = \frac{\hat{t}_{e_h}}{\hat{t}_{p_h}}$$

Where $\hat{t}_{e_h}$ is the total dollars in error projected for all the States (the universe) in stratum h, and $\hat{t}_{p_h}$ is the total projected payments for all of the States (the universe) in stratum h.

Total dollars in error for all the States in stratum h is projected by weighting the total projected dollars in error from the sampled States, which was calculated above for each State in the sample, by the inverse of the sampling frequency:

$$\hat{t}_{e_h} = \frac{N_h}{n_h} \sum_{i=1}^{n_h} \hat{t}_{e_{hi}}$$

In this equation N_h is the number of States in strata h, and n_h is the number of States in the sample that are in State stratum h. For example, if there are 17 States in stratum h, and the sample included 5 of those States, the total projected dollars in error for the universe of States in stratum h is the sum of the total projected dollars in error of each of the five States in h, weighted or multiplied by (17/5).

The analogous equation is used to project total payments in the stratum h universe:

$$\hat{t}_{p_h} = \frac{N_h}{n_h} \sum_{i=1}^{n_h} \hat{t}_{p_{hi}}$$

The error rate, for stratum h, is then the ratio of projected dollars in error to projected payments for that stratum, as defined above.

The final step is to apply the State stratum rates to data on actual expenditures for the period of the estimate. The estimated national error rate is calculated as:

$$\hat{R} = \frac{\sum_{h=1}^{4} t_{p_h} \hat{R}_h}{t_p}$$

where:

t_{p_h} = total universe payments for State stratum h

t_p = total universe payment

$\hat{R}_h$ =estimated error rate for stratum h

Note that there is no "^" over the State strata and national payment data. This means that they are not estimated from the sample. These are actual payment expenditures. Another way of considering the equation for the national error rate is to note that

$\frac{t_{p_h}}{t_p}$ = the share of national expenditures represented by States in stratum h.

Hence, the national error rate has an intuitive interpretation as a weighted sum of the estimated State stratum error rates, where the weights are shares of expenditures.

100.6 - Rolling Error Rate Calculation

The three-year trended national error rates have two components: (1) the error rates themselves, and (2) the trended error rates' variances, which are turned into the error rates' margins of error. Each of the trended payment error rates (i.e., total program, FFS, managed care, and eligibility) is calculated through the same methodology. The FY 2007, FY 2008, and FY 2009 payment

error rates were each weighted by the total applicable expenditures for that year and were then combined. The formula for the three year trended rate is as follows:[9]

$$\hat{R}_T = c_1\hat{R}_1 + c_2\hat{R}_2 + c_3\hat{R}_3$$

where:

R_T = the three-year trended error rate

R_1 = the FY 2007 error rate

R_2 = the FY 2008 error rate

R_3 = the FY 2009 error rate

c_1 = the weight for FY 2007, which is given by $N_1/(N_1 + N_2 + N_3)$, where N_1, N_2, and N_3 are the estimated payment totals for FY 2007, FY 2008, and FY 2009, respectively.

c_2 = the weight for FY 2008, which is given by $N_2/(N_1 + N_2 + N_3)$, where N_1, N_2, and N_3 are the estimated payment totals for FY 2007, FY 2008, and FY 2009, respectively.

c_3 = the weight for FY 2009, which is given by $N_3/(N_1 + N_2 + N_3)$, where N_1, N_2, and N_3 are the estimated payment totals for FY 2007, FY 2008, and FY 2009, respectively.

The weighted variance estimate ($\hat{Var}(\hat{R}_T)$) for any of the three-year error rates is given by the following formula: [10]

$$\hat{Var}(\hat{R}_T) = c_1^2\hat{\sigma}^2_{\hat{R}_1} + c_2^2\hat{\sigma}^2_{\hat{R}_2} + c_3^2\hat{\sigma}^2_{\hat{R}3}$$

where:

$\hat{\sigma}^2_{\hat{R}_1}$ = the estimated variance of the FY 2007 error rate

$\hat{\sigma}^2_{\hat{R}_2}$ = the estimated variance of the FY 2008 error rate

$\hat{\sigma}^2_{\hat{R}_3}$ = the estimated variance of the FY 2009 error rate

c_1^2 = the weight for FY 2007, which is given by $[N_1/(N_1 + N_2 + N_3)]^2$, where N_1, N_2, and N_3 are the estimated payment totals for FY 2007, FY 2008, and FY 2009, respectively

[9] See Hays, W.L., Statistics for the Social Sciences. Holt, Rinehart and Winston. 1973. Section 8.10.
[10] Ibid.

c_2^2 = the weight for FY 2008, which is given by $[N_2/(N_1 + N_2 + N_3)]^2$, where N_1, N_2, and N_3 are the estimated payment totals for FY 2007, FY 2008, and FY 2009, respectively

c_3^2 = the weight for FY 2009, which is given by $[N_3/(N_1 + N_2 + N_3)]^2$, where N_1, N_2, and N_3 are the estimated payment totals for FY 2007, FY 2008, and FY 2009, respectively

110- Corrective Action and Recoveries

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

The PERM program does not include new recovery requirements of the Federal portion of Medicaid and CHIP improper payments. 42 CFR 431.1002 explains States must return to CMS the federal share of identified overpayments based on the PERM data processing and medical reviews. Recoveries of overpayments are governed by longstanding statutory and regulatory requirements, for Medicaid under Section 1903(d)(2) of the Social Security Act, 42 CFR 433 part 433 subpart F and for CHIP under section 2105(e) of the Social Security Act, 42 CFR part 457 subparts B and F.

110.1- Corrective Action Process

Following each measurement cycle, the States included in the measurement are required to complete and submit a Corrective Action Plan (CAP) based on the errors found during the PERM process. CMS provides guidance to State contacts on the CAP process upon publishing of the PERM error rates and throughout the CAP development until the specified due date of the CAP; provided by CMS.

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.

A. PERM CAP Team

The role of the CAP Team is to support the corrective action phase of the PERM program by analyzing error rate data for the purposes of reducing improper payments in Medicaid and CHIP through corrective actions taken at the Federal and State levels. The PERM CAP Team will maintain a partnership with the States in an effort to foster collaboration and gain State participation in establishing PERM State-level corrective actions.

The PERM CAP Team is located in the CMS Central Office. Each PERM CAP Team member is assigned several regions, each year one PERM CAP Team member may be responsible for the majority of the seventeen states measured but over the three year cycle the number of Corrective Action Plans a PERM CAP Team member is responsible for is relatively evenly distributed amongst the members.

Kick-off Call: Once the States' error rates are posted on the website by the review contractor and released in the Agency Financial Report (AFR), the PERM CAP Team will have an initial "kick-off call" with each individual State to discuss their specific State findings, the corrective action process, and identify the state CAP contact person as well as a secondary contact person as a back-up

State Forum Call: CMS provides each State in the CAP phase of the PERM program with the opportunity to have a "State Forum Call" in which CMS provides a conference call line for the States to use and discuss best practices as they relate to developing corrective actions. While CMS provides the conference call line, a State volunteer within the cycle facilitates the discussions amongst the States. After the first State forum call, CMS allows States to decide whether a second call is needed for further discussion.

B. Corrective Action Panel

The key to a successful CAP is the formulation of a corrective action panel. The panel in turn must encourage participation and commitment of top management to coordinate efforts across the Agency and ensure participation of major department leaders.

Senior management could include managers responsible for policy and program development, field operations, research and statistics, finance, data processing, human resources (for staff development) and the legal department. These managers would comprise the corrective action panel. Leadership of the panel should rest with the State Medicaid or CHIP Director.

Responsibilities of the corrective action panel include:

- Providing insight on possible causes of errors
- Communicating the corrective action plan progress to management and other stakeholders
- Developing strategies
- Making all major decisions on the planning, implementation and evaluation of corrective actions

C. Components of the Corrective Action Plan

CAPs are composed of five elements as discussed below. The CAP template, instructions, and timeline are included at the end of this section.

Data Analysis - review clusters of errors, general error causes, characteristics, frequency of errors and consider improper payments associated with errors. Data analysis should sort the errors by:

- Type - general classification (e.g., FFS, managed care, eligibility).

- Element - specific type of classification (e.g., no documentation errors, duplicate claims, ineligible cases due to excess income).

- Nature - cause of error (e.g., providers not submitting medical records, lack of systems edits, unreported changes in income that caused ineligibility)

Program Analysis - This component is the most critical part of the corrective action process where States will review the findings of the data analysis to determine the specific causes of the errors. States will identify the root causes of the errors to determine the best solutions (e.g., why providers are not complying with medical records requests). The States may need to analyze the agency's operational policies and procedures and identify those policies and/or procedures that are more prone to contribute to errors, e.g., policies are unclear, lack of operational oversight at the local level.

Corrective Action Planning - Based on the data and program analysis, States must determine what corrective actions are to be implemented. States are encouraged to use the most cost effective corrective actions that can be implemented, to best correct and address the root causes of the errors. Your actions can be short or long term actions. Benefits for implementing corrective actions are reduction of improper payments and a management tool to promote efficiency in your program operations.

Implementation - Develop an implementation schedule for each corrective action initiative whether it is Statewide or just in certain geographical areas. The implementation schedule should identify major tasks, key personnel or components responsible for each activity, and a timeline for each action including target implementation dates, milestones including start and final implementation dates, and the monitoring process to be used for the corrective actions.

Evaluation - Evaluate the effectiveness of the corrective action by assessing improvements in operations and/or less incidence of errors. At some point States may need to decide whether the actions are effective at reducing or eliminating the errors. The States may then decide to discontinue, modify, or terminate and replace the corrective action with something new.

Subsequent corrective action plans would include updates on previous actions including:

- Effectiveness of implemented corrective actions using reliable data; such as performing special studies, State audits, focus reviews, etc.

- Discontinued or ineffective actions, and what actions were used as replacements;

- Findings on short-term corrective actions; and

- A status of the long-term corrective actions

D. Corrective Action Plan Timeline

Below is a sample corrective action plan timeline for Cycle 1 states. This timeline assumes that the FY 2009 CAP is implemented in FY 2011 and the FY 2012 CAP implemented FY 2014. Each CAP is in effect for 3 fiscal years and is updated by the subsequent CAP, e.g., the FY 2009

CAP in effect from March 2011 – March 2014 and the FY 2012 CAP in effect from March 2013-March 2016. Per this timeline, CAPs submitted to CMS and implemented by March 15th for the previous fiscal year error rate.

	2nd Three Year Rotation			3rd Three Year Rotation			4th Three Year Rotation		
Fiscal Year	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Review Period	Oct 2008 to Sept 2009	Oct 2009 to Sept 2010	Oct. 2010 to Sept. 2011	Oct 2011 to Sept. 2012	Oct 2012 to Sept 2013	Oct 2013 to Sept 2014	Oct 2014 to Sept 2015	Oct 2015 to Sept 2016	Oct 2016 to Sept 2017
PERM reviews, error rates and State corrective action plans	Conduct FY 2009 reviews.	1. States notified of FY 2009 State-specific error rates – Nov.15, 2010. 2. CMS reports national FY 2009 program error rates to the Department for FY 2010 AFR. 3. States begin FY 2009 corrective action analysis.	1. 2010 States submit and implement FY 2009 CAPs.	Conduct FY 2012 reviews.	1. States notified of FY 2012 State-specific error rates – Nov.15, 2013. 2. CMS reports national FY 2012 program error rates to the Department for FY 2013 AFR. 3. States begin FY 2012 corrective action analysis	1. 2011 States submit and implement FY 2012 CAPs.	Conduct FY 2015 reviews.	1. States notified of FY 2015 State-specific error rates – Nov.15, 2016. 2. CMS reports national FY 2015 program error rates to the Department for FY 2016 AFR. 3. States begin FY 2015 corrective action analysis	1. 2012 State submit and implement FY 2015 CAPs
Summary of Activities	Measure 17 States	Calculate FY 2009 error rates	FY 2009 CAPs in effect	FY 2009 CAPs in effect; Measure States again	FY 2009 CAPS in effect; Calculate FY 2012 error rates	New FY 2012 CAPs in effect; updates FY 2009 CAPs.	FY 2012 CAPs in effect until FY 2016.	FY 2012 CAPS in effect; Calculate FY 2015 error rates	New FY 2015 CAPs in effect; updates FY 2012 CAPs.

E. Corrective Action Plan Submission Details

CAPS are due into the assigned PERM CAP Team member on the due date communicated by CMS after the posting of the error rate on the Federal Contractors website. However, CMS encourages States to submit drafts to their designated PERM CAP Team member prior to the due date to receive feedback prior to the final CAP submission date. While drafts are not required, they are strongly encouraged. Once the drafts are submitted, CMS will review them and provide additional feedback that States can incorporate into their final CAP submission. Each State will receive a letter of receipt acknowledging their CAP submission upon receipt of their completed, final CAP.

The templates for the Corrective Action Plan Summary Form and the Detailed Corrective Action Plan can be found in Attachment 110-A.

Instructions for Completing the PERM Corrective Action Plan Summary Form

The corrective action plan summary will provide a summary (at-a-glance) of the State's measurement under PERM and resulting planned corrective actions. Attached to the summary sheet is the detailed description of the data analysis, program analysis, corrective action planning, implementation and evaluation.

The Corrective Action Plan summary provides an overview of the major causes of errors in each component of Medicaid and CHIP as identified by the State, and a summary of planned corrective actions for purposes of reducing improper payments.

States should complete one form for each component of each program.

Line A: Enter the name of the State submitting this report. Enter the Federal fiscal year in which the State is being measured in the PERM program. This should also be the same year for which the corrective action plan addresses.

Line B: Enter the date that the plan is submitted to CMS (e.g., October 31, 2008).

Line C: Enter the name, phone number and e-mail address of the State person assigned as the contact person for the corrective action plan.

Line D: Enter the State's payment error rate for the Medicaid program as reported by CMS.

Line 1. Enter the State's Medicaid fee-for-service error rate as reported by CMS.

Line 2: Enter the State's Medicaid managed care error rate as reported by CMS.

Line 3: Enter the State's eligibility payment error rate as reported by the State.

Line E: Enter the State's payment error rate for the Children's Health Insurance Program (CHIP) as reported by CMS.

Line 1: Enter the State's CHIP fee-for-service error rate as reported by CMS.

Line 2: Enter the State's CHIP managed care error rate as reported by CMS.

Line 3: Enter the State's eligibility payment error rate as reported by the State.

Line F: Provide a summary of causes of errors found in each component (fee-for-service, managed care and eligibility) of the State's Medicaid and CHIP programs. Include a general description of the State's planned corrective actions designed to address the major cause of the errors. It may be more cost effective to place first priority on errors that are wholly within your control. Examples of a general description of the corrective actions are systems edits, provider education, and staff training.

Instructions for Completing the PERM Detailed Corrective Action Plan

States should complete one form for each component of each program.

Line A: Enter the name of the State submitting this report. Enter the Federal fiscal year in which the State is being measured in the PERM program. This should be the same year for which the corrective action plan addresses.

Line B: Enter the name, phone number and e-mail address of the State person assigned as the contact person for the corrective action plan.

Line C: Enter the program for which this corrective action plan addresses (i.e., Medicaid or CHIP).

Line D: Enter the component for which this corrective action plan reflects (i.e., fee-for-service, managed care or eligibility).

Line E: Narrative Instructions - for each component of each program, provide a discussion of the results of following elements.

1. Data Analysis: What clusters of errors, causes, characteristics, and frequency were identified through the data analysis? Describe the results of the data analysis by:

- Element – specific type of classification of errors
- Nature – cause of errors

2. Program Analysis: Describe why a particular program/operational procedure caused the specific error and identify the root causes of errors (e.g., provider manuals are unclear or outdated; eligibility staff needs training on application of earned income).

3. Corrective Actions: Describe the corrective action initiatives to be implemented and how it will reduce or eliminate the improper payments. Be sure to include:

- Error causes being targeted
- Expected results.

4. Implementation: Implementation should describe the major and minor tasks necessary for implementation and each should include a timeline including milestones

and implementation dates. Be sure to describe how the corrective action will be monitored for effectiveness.

110.2- Recoveries

For purposes of PERM, States are considered to be officially notified by CMS of identified improper payments by the 1) posting of Medicaid and CHIP errors on the designated CMS Review Contractor website and 2) by receiving an official letter with "notification of an overpayment" via email.

The posting occurs on the first business day of each month (once medical and data processing reviews commence). The website postings contain the errors that have gone through the difference resolution and CMS appeals process, as applicable, where the error findings were upheld. These postings will be separately identified from claims posted for initial difference resolution.

The Patient Protection and Affordable Care Act (the Affordable Care Act), section 6506, states that effective March 23, 2010 States now have up to one year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment. There is one exception in cases of overpayments resulting from fraud. See details in the State Medicaid Directors Letter (SMDL# 10-014) dated July 13, 2010.

For overpayments identified prior to the effective date, the previous rules on discovery of overpayments will be in effect which provides 60 days from the date of discovery of an overpayment to recover such overpayment before making the adjustment to the Federal share. This change to the federal laws does not affect the treatment of federal credit for amounts actually collected prior to the expiration of the one year, once funds are collected from the provider the Federal share are still due on the next quarterly CMS-64. This posting of CHIP claims in error and receiving an official letter of notification of an overpayment via email also serves as the official CMS notification for the refunding of overpayments in CHIP, which are to be refunded on a quarterly basis on the next CMS-21. States should follow the current CMS process for refunding Federal payments.