

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

**Fiscal Year 2007**

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## 1. Introduction

The Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, enacted on November 26, 2002, requires the heads of Federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments to estimate the amount of improper payments, to report those estimates to the Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures. The Office of Management and Budget (OMB) identified Medicaid and the State Children's Health Insurance Program (SCHIP) as programs at risk for significant improper payments. More information on the PERM program can be accessed at <http://www.cms.hhs.gov/MedicaidPERM> and <http://www.cms-perm.org>.

To implement the requirements of IPIA, CMS developed the Payment Error Rate Measurement (PERM) program. Under PERM, reviews will be conducted in three areas: (1) fee-for-service (FFS), (2) managed care, and (3) program eligibility for both the Medicaid and SCHIP programs. The results of these reviews will be used to produce national program error rates, as required under the IPIA, as well as State specific program error rates. CMS has developed a national contracting strategy for measuring the first two areas, FFS and managed care, mentioned above. States will be responsible for measuring the third area, program eligibility, for both programs. Because States administer Medicaid and SCHIP according to each State's unique program, the States necessarily need to be participants in the measurement process. CMS will use PERM to measure Medicaid and SCHIP improper payments in a subset of States each year. To enable States to plan for the reviews, States will be reviewed on a rotating basis, so each State will be measured for improper payments in each program once and only once every three years.

The States that will be measured for fiscal years (FY) 2007-2009 (which will rotate thereafter) are as follows:

### States Selected for Medicaid and SCHIP Improper Payment Measurements

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

National contractors selected by CMS will conduct the medical and data processing reviews to develop error rates in the fee-for-service and managed care components of Medicaid and SCHIP. States will conduct the eligibility reviews of Medicaid and SCHIP cases and calculate State-specific eligibility error rates for reporting to CMS. CMS' statistical contractor will combine the State-reported eligibility error rates to develop national eligibility error rates for Medicaid and SCHIP.

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

fulfill the requirements of the IPIA and is not intended to supplant, enhance, or change other program integrity activities in which the States are currently engaged. We are providing the option for States to contract out the eligibility measurement to entities independent of States' Medicaid and/or SCHIP eligibility determination and enrollment activities. We are considering methods to minimize duplication of efforts regarding the eligibility reviews. As we work with all States and gain experience with the Medicaid and SCHIP eligibility measurement, we may consider program refinements that improve the process, for example, by improving the timeliness and accuracy of the reviews and by maximizing the use of limited resources.

CMS has compiled these instructions for the FY 2007 eligibility reviews to provide guidance to States on the eligibility measurement process from initial sampling to final reporting. The instructions provide step-by-step guidance, flowcharts and a timeline that illustrates the eligibility measurement process. Eligibility reviews will encompass cases currently on the program, i.e., active cases and cases that were denied or terminated from the program, i.e., negative cases. States will calculate both a case and a payment error rate for active cases and a case error rate for negative cases. A glossary is provided that defines terms used throughout these instructions. Finally, CMS has designated the first quarter of FY 2007 as an implementation timeframe for States to prepare for the FY 2007 eligibility reviews, which will be condensed over a nine month timeframe (refer to the eligibility measurement timeline in Appendix A).

## 2. Sampling

This section provides statistical and operational guidance for sampling cases from which to estimate eligibility error rates for Medicaid and SCHIP. The programs are measured separately. **It is important to note that, for purposes of the PERM reviews, cases included in the Medicaid universe are those where all services are *paid with title XIX funds*, and cases included in the SCHIP universe are those where all services are *paid with title XXI funds including Medicaid-expansion cases that are funded under SCHIP*. Also note that, for PERM purposes, a "case" is defined as an individual beneficiary, not a household or family unit.**

States participating in FY 2007 must submit a sampling plan for each program including both the active and negative case samples, developed in compliance with applicable regulations and these instructions, to CMS' statistical contractor for approval by November 15, 2006. The statistical contractor will work with any State to ensure the sampling plan meets the requirements in these instructions and is approved by January 15, 2007.

This section is divided into two parts. The first part describes the sample for estimating a case and a payment error rate for active cases. For FY 2007, the full sample will be drawn over a nine month period, from January through September 2007. The second part of this section describes the sampling plan for determining the case error rate for negative cases. Although States will draw separate samples for Medicaid and SCHIP, the procedures for sampling are the same for both programs. These instructions will distinguish between Medicaid and SCHIP only when differences occur (e.g., how the universe for each program is defined).

States will calculate two error rates for active cases. The first is a "dollar weighted" or "dollar" error rate using the dollar value of payments made for services. In addition, a simple case error

rate (eligible or ineligible) is computed. The same active case sample will be used for both the payment error rate and the case error rate. The error rate for negative cases, which is not dollar weighted, is a case error rate only.

States can cite a case as “undetermined” if after due diligence an eligibility determination could not be made. States will identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the first 30 days of eligibility, the review month or sample month, as appropriate. States will report all “undetermined” cases and payment amounts for these cases.

## **2.1. Sampling for Active Cases**

An active case is a case that contains information regarding an individual beneficiary enrolled in the Medicaid program or in the SCHIP program in the sample month. Note that the distinction in enrollment is determined by the program funding the services, that is, a Medicaid-expansion case is included in the SCHIP sample (and universe) if the beneficiary’s services are paid by Title XXI funds.

### **2.1.1. Active Case Universe**

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

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

Exclusions from the active case universe for the active case sample each month are:

- All cases that were denied based on complete or incomplete applications or terminated based on complete or incomplete redeterminations, i.e., negative cases;
- Cases under active fraud investigation as defined in Appendix B;
- For Medicaid only, Supplemental Security Income cash cases in States with an agreement with the Social Security Administration under section 1634 of the Social Security Act, and
- For Medicaid only, adoption assistance and foster care cases under title IV-E.

### **2.1.2. Stratifying Active Cases**

For each sampling month, States will stratify the active case universe into three strata according to the type of active case. Active cases strata are:

- stratum one: applications. A case constitutes an “application” for the sampling month if the State took an action to grant eligibility in that month based on a completed application.<sup>1</sup> These cases are placed into stratum one.
- stratum two: redeterminations. A case constitutes a “redetermination” for the sampling month if the State took an action to continue eligibility in the sample month based on a completed redetermination. These cases are placed into stratum two.
- stratum three: all other cases. All other cases (properly included in the universe but do not meet the strata one or two criteria) that are on the program in the sample month are placed in stratum three.

Note that there are no provisions for a State to drop a case from review and replace it with another case. If a case cannot be completed, it should be cited as “undetermined.” The exception is when the State inadvertently samples a case that should have been excluded from the universe. For example, if a case under an active fraud investigation is sampled, it should be dropped and replaced with a randomly selected case in the same stratum. When developing the sampling plan, States should consider the potential need for randomly selected replacement cases. States should also develop a quality control review of the universe to ensure that cases that should be excluded from the universe are actually excluded before the stratification and sampling is conducted, to reduce the potential for future drops.

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

**Exhibit 2.1: Active Case Stratification for FY 2007**

Stratum	Month								
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
<b>1. Applications</b>									
<b>2. Redeterminations</b>									
<b>3. All Other Cases</b>									

**2.1.3. Sample Size for Active Cases**

The sample size is calculated under the assumption that the error rate is 5 percent.<sup>2</sup> This means that the desired precision requirements will be achieved with a high probability if the actual error rate is 5 percent or less. For this reason, an annual sample of 504 cases should meet State-

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<sup>1</sup> States should count an individual reapplying for Medicaid or SCHIP after a break in eligibility as a new application and place the case in stratum one.

<sup>2</sup> In subsequent years, the State should use its most recently calculated PERM eligibility error rate to determine its sample size. This error rate and sample size should be included in the State’s sampling plan for the next measurement period, along with the documentation and analysis.

level precision requirements with a high probability. In subsequent years, if the State’s actual error rate is below 5 percent, the State may demonstrate that a smaller sample size based on the documented lower error rate is sufficient. The case for a smaller sample size should be made in the State’s sampling plan for FY 2010 and subsequent years, along with the documentation and analysis to demonstrate that a smaller sample size will achieve required precision goals.<sup>3</sup>

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

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

and

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

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

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

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

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

<sup>3</sup> If the total population from which the total (full year) sample is drawn is less than 10,000, the State may make a case to reduce the sample size by the finite population correction (fpc) factor. If so, the required sample size becomes:

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

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

Sample sizes should be sufficient to meet the precision requirements, which is to estimate the active case payment error rate within 3 percentage points of the population mean error rate with a 95 percent level of confidence. Sample sizes differ depending on the State's underlying error rate. Exhibit 2.2 shows the probability of achieving the desired precision for a given sample size and assumed error rate. If the underlying error rate is in the range of 3 to 4 percent, a sample size of 504 total cases will achieve the desired precision level with very high probability. Moreover, a sample of 504 will achieve the precision level more than 50 percent of the time with an error rate as high as 6 percent.

**Exhibit 2.2: Probability of Achieving Precision for Certain Error Rates and Sample Sizes**

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

#### 2.1.4. Method for Drawing the Monthly Sample

States will draw the total sample over the course of nine months, with each monthly sample drawn from a universe that is unique for the month. The total sample size will be 504 cases for the active case payment error rate, unless the State has an approved sampling plan with a reduced sample size based on the finite population correction. After the end of each month, but no later than the 15<sup>th</sup> day of the subsequent month, the State should gather the universe data, stratify the cases in the universe for that month into stratum one, applications; stratum two, redeterminations; and stratum three, all other cases, and request the case records for the sampled cases. For determining which stratum applies, the State should evaluate the date of the last action taken by the State in the sample month, not the effective date of the action.

Example: A case is sampled in January. The case is eligible as of January 1 and would normally be placed in stratum three "all other cases." However, the State took action to redetermine eligibility on January 15<sup>th</sup> for a new period of eligibility effective February

1.<sup>4</sup> In this example, the case should be put in stratum two “redeterminations” for the January sample month because the last action the State took in the sample month was to continue eligibility based on a redetermination.

Note that over the nine months, cases will appear in the universe more than once, may be in different strata in different months, or may be randomly drawn in more than one month over the course of the measurement.

Because a unique universe is drawn each month, a beneficiary could appear in stratum one month and stratum three the next month, and in stratum two or stratum three the next month. Given the small size of the sample, it is unlikely that a beneficiary will be randomly selected more than once. However, if the case is selected in more than one month, it should not be dropped and replaced with another case but instead should be included in the sample.

The main concern in the sampling process is how many cases to sample from each of the three active case strata each month. Standard sampling theory would suggest sampling in proportion to the number of dollars represented in the strata. However, because stratum three (all other cases) clearly contains the majority of payments, this rule would lead to a large sampling of beneficiaries from this stratum. Also, we have no information regarding the variation in errors or payment across the strata. Therefore, in the absence of better information, an equal number of cases will be drawn from each of the three strata each month in future years over a 12 month period unless otherwise provided for in the plan approved by CMS.

In FY 2007, the sample will be drawn from the last nine months of the year, as shown in Exhibit 2.3, but the number sampled in each month will be increased proportionately to obtain the same overall sample size in each of the three strata as would be used with a full 12-month sample. Unless the State has an approved alternative due to the finite population correction<sup>5</sup>, 18 cases will be sampled each month in each stratum for the second quarter of FY 2007 (January, February, and March), while 19 cases will be sampled each month in each stratum in the third and fourth quarters of FY 2007 (April through September).

**Exhibit 2.3: Sample Size by Stratum in FY 2007**

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

<sup>4</sup> Most States redetermine eligibility by projecting categorical and financial circumstances to the next month.

<sup>5</sup> If the State’s universe for the previous fiscal year is less than 10,000, it may demonstrate in its sampling plan to apply the finite population correction to reduce its sample size.

Within the strata, the required number of cases should be sampled randomly, as soon as possible after the end of the sample month, once the universe for that month is determined. However, the sample should be drawn and reported to CMS no later than the 15<sup>th</sup> day of the month following the sample month (see Section 6 Reporting). This timeframe includes requesting the case records for the review process. The random sample of cases for that month should be without replacement.

The monthly samples should be subject to quality control procedures to ensure that inappropriate cases were excluded from the universe and that all appropriate cases were included. A monthly sample selection list must be submitted to the statistical contractor as specified in **Section 6**.

### **2.1.5. Sampling for Negative Cases**

Negative cases are cases where the State denied an application or terminated on-going eligibility. A negative case contains information on a beneficiary who completed an application for benefits and the State denied the application or who completed the redetermination process but whose program benefits were terminated by the State. The sampling plan for negative cases should be included with the sampling plan for active cases for submission to the statistical contractor by November 15, 2006.

### **2.1.6. Negative Case Universe**

A unique universe is created each month. All cases where the State denied eligibility based on a completed application in the sample month and all cases where the State terminated eligibility in the sample month should be included in the universe for that month. All other active cases including cases still on the program pending the required 10-day notice of termination and cases where benefits are properly being continued pending an appeal of termination should be excluded from the respective month's negative case universe. No other exclusion criteria apply. There are no provisions for States to drop cases from review and replace them with other cases.

### **2.1.7. Negative Case Sample**

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

### **2.1.8. Sample Size for Negative Cases**

A minimum sample size of 204 is required. However, if the State's universe for the previous fiscal year is less than 10,000, it may request to apply the finite population correction to reduce its sample size. The State should make the case for a reduced sample size based on the finite population correction in its sampling plan, as indicated in section 2.1.3. However, the reduction is likely to be small.

The negative case error rate is not dollar weighted; it is a simple binomial. The equation for sample size is the same as the previous equation in section **2.1.3. Sample Size**, except that K is zero:

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

The required sample size is that which is sufficient to obtain a precision level of 3 percentage points at the 95 percent confidence level for the negative case error rate. If the error rate is less than 5 percent, a sample size of 204 will achieve that precision level more than 50 percent of the time. If the error rate is 3 percent or 4 percent, a sample size of 204 will achieve the precision goal with a high probability. <sup>6</sup>

**2.1.9. Method for Drawing the Monthly Sample**

States will draw the total sample of 204 cases over the course of nine months in FY 2007 and 12 months in subsequent years. After the end of each sample month, but no later than the 15<sup>th</sup> 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. In FY 2007, the sample will be drawn from this universe of negative cases over the last nine months. Hence, the sample size should consist of at least 22 cases for three months and 23 cases for the last six months, as shown in Exhibit 2.5, unless CMS approves a reduced sample size due to the finite population correction.

The monthly samples should be subject to quality control procedures to ensure that the appropriate cases were included in the universe, and that inappropriate cases excluded. A monthly sample selection list must be sent to CMS' statistical contractor prior to commencing the reviews as specified in **Section 6**.

**Exhibit 2.5: Sample Size by Stratum in FY 2007**

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

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<sup>6</sup> In subsequent years, if the State's actual error rate is below 5 percent, the State may demonstrate a smaller sample size based on the documented lower error rate. The case should be made in the State's sampling plan for FY 2010, along with the documentation and analysis to demonstrate that a smaller sample size can achieve required precision goals.

### 3. Eligibility Reviews of Active Cases

All sampled active cases are reviewed to verify that the individual was eligible for the program. All case reviews must be conducted by an agency independent (i.e., agency and personnel must be functionally and physically separate) of the State agency responsible for Medicaid and SCHIP policy and operations or the State agency making program eligibility determinations. This requirement helps ensure the independence of the reviews. The State must identify the agency or the contracting entity responsible for the eligibility reviews in its sampling plan with a stated assurance that the agency is independent of the State agency responsible for eligibility determination and enrollment or that the contracting entity is independent of the State's eligibility and enrollment activities.

States should complete 90 percent of case reviews within 105 days of the end of the sample month, 95 percent within 125 days of the end of the sample month, and complete and report detailed findings on 100 percent of the cases within 150 days of end of sample month (see **Section 6. Reporting**). For a timeline of the complete eligibility measurement process, please see Appendix B.

#### 3.1. Review Month vs. Sample Month

The review month is when eligibility is verified because, for PERM purposes, the review month is when the State's last action occurred. The exception to verifying eligibility as of the review month is when the State's last action occurred more than 12 months prior to the sample month. In those instances, eligibility for the case is verified as of the sample month.

Example 1: A case is sampled in January 2007. The State's last action (the review month) occurred in May 2006. Eligibility for this case is verified as of the review month of May 2006.

Example 2: A case is sampled in January 2007. The State's last action (the review month) occurred in December 2005. Since the last action occurred more than 12 months prior to the sample month of January 2007, eligibility is verified as of January 2007.

The sample month is the month in which the case is sampled for review.

For cases in stratum one "applications" and stratum two "redeterminations," the review month and the sample month are the same. For cases in stratum three "all other cases," the review month is the month of the State's last action and is usually a month different from the sample month.

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

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

There is no administrative period for the PERM eligibility reviews. The administrative period is defined under 42 CFR section 431.804, as a timeframe under the MEQC program that provides States with a reasonable period of time to reflect changes in the Medicaid beneficiary's circumstances without an error being cited. (The administrative period does not apply to SCHIP.) This period consists of the review month and the prior month. We are not applying this concept to the PERM eligibility reviews for the following reasons: 1) The administrative period is not applicable for those cases in strata one and two because these cases are reviewed as of the State's most recent action. 2) For cases in stratum three, eligibility also is verified as of the State's last action unless that action occurred beyond 12 months from the sample month. In those instances, the administrative period would not be applied because the State should not be held harmless when it has not complied with the requirements at 42 CFR 435.916(a) and 457.320(e)(2) to redetermine eligibility at least annually.

### 3.2. Verification Standards

The purpose of the case review is to verify eligibility following State policies in effect at the time of the review (so long as the policies comply with the State plan or, if the plan is silent, Federal laws and regulations). The standards discussed below determine the extent to which the review obtains evidence relevant to the beneficiary's eligibility or ineligibility. CMS has established these standards to provide a systematic and nationally uniform method of verifying eligibility. However, these verification standards are not all inclusive. If the agency is unable to obtain the documentation specified, eligibility can be verified through other reasonable evidence.

#### 3.2.1. Acceptable Documentation

The agency must examine the evidence in the case file and, if needed, independently verify elements of eligibility where evidence is: (1) missing; or (2) outdated (i.e., older than 12 months from the sample month) and likely to change. Exhibit 3.1 lists the categorical and financial criteria that are or are not likely to change.

**Exhibit 3.1: Criteria Likely or Not Likely to Change**

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

Sufficient evidence of documentation in the case file includes:

- Documentation from a reliable third-party source, e.g., employer wage statement showing earned income for the month eligibility is being verified;
- Caseworker notes in reasonable instances:
  - To verify residency: "Visit to Susie Jones at assisted-living home. Ms. Jones is residing there."
  - To verify income: "Conducted a home visit and verified Bank of America statement for checking account #12345, dated March 2007, with an ending balance of \$55.07 and no unusual deposits or withdraws other than the Social Security benefit of \$700.";
- Permanent documents (e.g., birth certificate, Social Security card, etc., regardless of when the document was obtained); and
- Self-declaration that complies with section 3.2.2, below.
- Also refer to section 7269 of the State Medicaid Manual (SMM) for listings of acceptable primary and secondary documentation for each element of eligibility.

### **3.2.2. Acceptable Self-Declaration**

CMS allows States to accept self-declaration of certain categorical and financial eligibility criteria as a means to simplify the application and redetermination eligibility processes. For example, rather than requiring documented proof such as a birth certificate, some States accept a signed statement, under penalty of perjury, as proof of birth date/age. Some States also accept a signed statement for other categorical and financial criteria as long as there is no Federal requirement to document the information., such as the Deficit Reduction Act of 2005, which requires documentation of citizenship for Medicaid effective July 1, 2006. State Medicaid policy that allows for self-declaration of citizenship will need to be revised to comply with this new requirement. These citizenship verification requirements do not apply to separate SCHIP programs and States may adopt their own requirements in this regard for SCHIP. States should refer to Federal Medicaid and SCHIP eligibility rules at 42 CFR Part 435 and Part 457 for other Federal verification requirements.

Self-declaration is considered acceptable verification for meeting categorical and financial requirements listed as unlikely to change in Exhibit 3.1 and are not required by Federal law or regulation. The self-declaration must be in accordance with official written State policy, and the attestation must be:

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

If the self-declaration fails to meet these standards, the agency must verify the self-declaration (1) through documentation as of the month eligibility is being verified for Medicaid, or (2) with documentation or a new self-declaration statement from the beneficiary for the month eligibility is being verified for SCHIP that meets the State's official written policy. The new self-

declaration is acceptable if it is not inconsistent with facts in the case record or resolves inconsistencies in the case record. If the new self-declaration is not acceptable and the agency cannot verify eligibility through other means, cite the case as “undetermined.”

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

For Medicaid, States must always verify through documentation:

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

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

### **3.3 PERM Technical Errors**

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

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

### **3.4 Process for Conducting Medicaid and SCHIP Active Case Reviews**

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

Also, note that to facilitate and expedite the eligibility process in certain situations, under Federal law States may provide presumptive eligibility, which might include:

- Pregnant women,

- Women with breast or cervical cancer,
- Children, and
- People with disabilities being discharged from the hospital into the community (section 6086 of the DRA that amends section 1915 of the Act).

Presumptive eligibility for Medicaid allows States to enroll beneficiaries, for a limited time before the beneficiary is required to file a full application. These cases, for both Medicaid and SCHIP, are reviewed according to State policies as long as they comply with the State plan, Federal law, or both. Verify whether the case is within the presumptive eligible period. If so, cite the case as eligible. If not, verify that, for Medicaid, an application was filed and the beneficiary is eligible for the program. Verify SCHIP eligibility according to State policies governing this coverage group.

Continuous eligibility is when coverage is extended to a beneficiary at time of application or redetermination for a predetermined period without regard to changes in income as provided by Federal Medicaid law at section 1902(e)(12) of the Act or applicable SCHIP law or regulations. To review cases in continuous eligibility status, verify eligibility as of the date the State took the action to grant continuous eligibility based on application or redetermination. However, if the State's last action occurred 12 months before the sample month, eligibility is verified as of the sample month.

**Step 1.** Determine the sample month and review month for the case, and 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, verify eligibility as of the review month. If the last action was taken beyond 12 months from the sample month, verify eligibility as of the sample month.

**Step 2.** Determine the State criteria for eligibility (i.e., categorical and financial criteria to be met for the coverage group under which the case is being reviewed). Examine the evidence in the case file that supports categorical and financial eligibility. Verify information that is missing, more than 12 months old and likely to change, inconsistent with other facts, unacceptable under self-declaration guidelines, or required under these instructions.

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

- a. If the beneficiary was ineligible for Medicaid, continue to Step 4.
- b. If the beneficiary was eligible for Medicaid, cite the case "ineligible" for SCHIP and proceed to Step 5.

**Step 4.** Verify program eligibility. For Medicaid, verify eligibility for the Medicaid coverage group in which the person is receiving services based on acceptable documentation. For SCHIP, verify the case is eligible based on acceptable documentation by meeting all SCHIP eligibility criteria.

- a. If the beneficiary is eligible, cite the case "eligible" and proceed to Step 4c.
- b. If the beneficiary is ineligible for the coverage category, determine eligibility for other related coverage categories.
  - i. If after examining all related categories, the beneficiary is still ineligible for the program, cite the case "ineligible" and proceed to Step 5.

- ii. If the beneficiary is eligible for the program but under another coverage category, cite the case eligible and proceed to Step 4c.
- c. Determine whether the beneficiary was enrolled in managed care.
  - i. If the beneficiary was not enrolled in managed care, proceed to Step 5.
  - ii. If the beneficiary was enrolled in managed care, verify residency and determine whether the beneficiary was eligible for managed care and enrolled in the correct plan. The agency should review the State's managed care enrollment criteria to establish whether the beneficiary is eligible for managed care and, if so, that the beneficiary was enrolled in the correct managed care plan as of the month eligibility is being verified.
  - iii. If the beneficiary was ineligible for managed care, cite the case MCE1 (managed care error, ineligible for managed care) or was eligible for managed care but was enrolled in the wrong plan, cite the case MCE 2 (managed care error, eligible for managed care but improperly enrolled) and proceed to Step 5.
  - iv. If the beneficiary is eligible and enrolled correctly, proceed to Step 5.
- d. If the agency cannot verify eligibility or ineligibility, the following process must be followed prior to citing the case as "undetermined." When information cannot be obtained from a review of the case record and/or through independently obtained documentation or outside sources such as employers, contact the beneficiary to obtain the needed information. Listed below are the minimum efforts (all of which must be performed) required to contact the beneficiary.
  - Three phone calls to all valid known beneficiary phone numbers, on varying days and at varying times of day;
  - One certified letter to all known mailing addresses; and
  - Two contacts with reliable collateral sources (e.g., landlord, relatives, employers).

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

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

**Step 5.** Record the Medicaid or SCHIP case review finding "eligible," "ineligible," or "undetermined." (Managed care cases that are eligible for Medicaid or SCHIP are considered as eligible cases but record the amount of misspent dollars associated with any managed care errors for inclusion in the error rate calculation.) The findings should be forwarded to the State agency responsible for eligibility determinations so appropriate actions on individual cases can be taken. Note technical errors as approved by CMS so that the State can take corrective actions to reduce or eliminate these types of errors.

### 3.5 Process for Conducting Medicaid and SCHIP Negative Case Reviews

The negative case review process, which is identical for both Medicaid and SCHIP, is described below. The negative case reviews may be limited to the review of the case record. Personal interviews are optional. For a flowchart of the Medicaid and SCHIP Negative Case Review Process, please see Appendix G.

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

**Step 1.** Review the notice of action to identify the reason the State denied or terminated eligibility. Reasons for denials and terminations of Medicaid or SCHIP can be for any circumstance, e.g., reasons are not limited to denials or terminations based on income.

**Step 2.** Examine the evidence in the case file to verify whether the State's reason for denial or termination was correct. For example, if the case was denied due to excess income, review the income documentation in the case file to determine whether it exceeded State income levels. For details on what constitutes sufficient evidence in the case record, please see section 3.1.1. **Acceptable Documentation** in these instructions as well as section 7269 of the **State Medicaid Manual**.

- a. If the reason for the beneficiary's denial or termination of benefits was correct, cite the case "correct."
- b. If the reason for the beneficiary's denial or termination of benefits was incorrect, determine whether the evidence in the case record supports the negative action for any other reason, e.g., the State erroneously terminated eligibility based on excess income but the review verified that the termination was actually correct because the case has excess resources.
  - i. If the evidence indicates another reason for denial or termination, cite the case "correct."
  - ii. If no evidence exists to support the denial or termination, cite the case "improper denial" or "improper termination."

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

#### 4. Payment Reviews of Active Medicaid and SCHIP Cases

Payment reviews must be conducted to determine the active case payment error rate, which is a dollar-weighted error rate. States must collect the claims and managed care payments associated with the cases in the sample. The dollar values of the payments and payment errors associated with these cases will form the basis of the dollar-weighted error rate.

The agency will collect payments for services received in the review month, first 30 days of eligibility or the sample month, as appropriate to the case under review, and paid in that month and in the four months following that month (because submission and payment of a claim lags behind the date of service). For example, if the agency is collecting claims for the sample month of January, all fee-for-service claims with a service date in January will be collected if the payment date was in January, February, March, April, or May. In addition, all adjustments that occur within 60 days of the payment date should be included with the claim. Any adjustments to claims that are the result of the eligibility reviews should not be included for the purposes of calculating the eligibility error rate.

Claims are collected and associated with a case in accordance with the State's policy on effective date of eligibility. For example, most States provide "full month" coverage in that, if a beneficiary is eligible at any point during the month then the beneficiary's eligibility is effective retroactive to the first day of the month. Other States have "date-specific" eligibility in that eligibility is effective prospectively.<sup>7</sup> The effective date of coverage dictates how the agency will associate claims as follows:

- in States with full month coverage, the agency would associate all payments for services received in the review month (strata one and two cases);
- in States with date-specific eligibility, the agency would associate all payments for services received in the first 30-days of eligibility (strata one and two cases); and
- for all cases in stratum three, the agency would associate all payments for services received in the sample month.

All managed care payments made for coverage in the review month for strata one "applications" and two "redeterminations" cases or in the sample month for stratum three "all other cases" are included regardless of the actual payment date so long as the payment dates fall within the five-month timeframe.<sup>8</sup>

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<sup>7</sup> Note that the PERM eligibility reviews will not encompass the three-month retroactive period in Medicaid. SCHIP has no retroactive eligibility period.

<sup>8</sup> In some States, managed care payments are made to managed care organizations in the month before or the month following the month of coverage. Prospective payments for the sample month will be counted.

#### 4.1. Instructions for Conducting Medicaid and SCHIP Payment Reviews

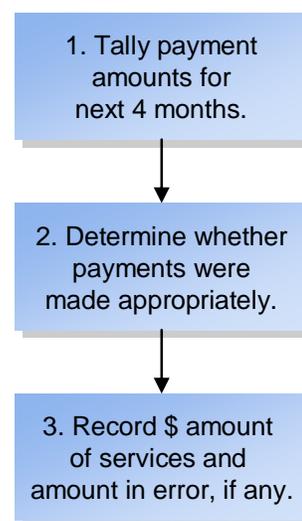
The payment review process, which is identical for Medicaid and SCHIP, is described below. For each case, the agency will:

**Step 1.** Collect claims and capitation payments for services received (and paid in the month and four months following the month) within the:

- a. First 30 days of eligibility or the review month for strata one and two cases (applications and redeterminations) according to the State's effective date of eligibility policy.
- b. Sample month for all other cases.

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

NOTE: The PERM eligibility reviews measure improper payments that are paid within a fiscal year. Payments made outside the fiscal year are not counted even if the payments were made for services rendered in previous fiscal years. For cases in strata one and two, if the State has date-specific eligibility and if a 30-day period of eligibility extends beyond the Federal fiscal year being measured, only consider claims paid for services received until the end of the fiscal year. For example, if the sample drawn in September 2007 includes a case for which the eligibility began on September 15, consider only claims for services received from September 15 through September 30.



**Step 2.** Verify whether the payments were made appropriately based on the eligibility review findings. The payment review may include determining if the beneficiary met his/her liability amount or cost of institutional care, and could result in a liability overpayment or liability underpayment error depending on whether the beneficiary paid too little or too much toward his cost of care. The payment review should also determine whether the beneficiary was eligible for the services received. For example, if a beneficiary is eligible for Medicaid as medically needy (which has limited benefit packages) and received a wide range of services, the case may be "eligible with ineligible services" if the beneficiary received services not covered under the medically needy group according to the State's plan. Payments for services for which the beneficiary is not eligible to receive are considered improper and are included in the error rate calculation. Although "eligible with ineligible services" results in a payment error, the case determination of eligible should be counted as correct. Managed care cases that are eligible for Medicaid or SCHIP are considered as eligible cases but record as improper payments any amount of misspent dollars associated with managed care errors due to ineligibility for managed care or improper enrollment in a plan for inclusion in the error rate calculation.

**Step 3.** Record the amount of dollars attributable to the entire case, the amount of correct payments and the amount of dollars in error, if any (see **Section 6. Reporting**). States must be able to identify overpayments and underpayments.

**Step 4.** For “undetermined” cases where eligibility could not be verified, collect and tally the claims as of the sample month and record the amount for each undetermined case.

States must complete and report payment reviews within 60 days after the first day of the month in which the claims collection process begins. **Section 6. Reporting** includes a discussion of reporting due dates.

## 5. Calculating Medicaid and SCHIP Eligibility Error Rates

The State must calculate the eligibility error rates for each program and report in accordance with **Section 6**. This section describes the calculation of the error rate, its variance, and a confidence interval around the error rate estimate for both active and negative cases. A total of three error rates will be calculated for Medicaid and for SCHIP.

For active cases, the following error rates are calculated:

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

For negative cases:

- A negative case error rate.

For undetermined active cases:

- The number of cases for which a verification of eligibility could not be made during the review.
- The payments for services rendered during the review month, first 30 days of eligibility or the sample month for these cases.

This section describes a particular estimator for the calculation of the Medicaid and SCHIP eligibility error rates.

### 5.1. Calculating Active Case Payment Error Rates

The active case sample will have included a specified number of cases each month for each of the three strata. The method for estimating the error rate is called the combined ratio estimator.<sup>9</sup> The payment amounts and amounts of payments in error associated with a case consist of all the fee-for-service claims incurred by the case with a date of service in the review or sample month, as appropriate, and that were paid in the five-month period beginning with the month of service. Managed care payments consist of all managed care payments made on behalf of the case for coverage of services in the month the case was sampled. The basic strategy of the combined ratio estimator is to estimate total errors and total payments based on the sample information. The sampling frequencies are used to project errors and payments observed in the sample to the State population values. This strategy, then, provides appropriate payments to combine the errors across each of the three strata into a single error rate for the universe.

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

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<sup>9</sup> For additional discussion of the combined ratio estimator, see for example, William G. Cochran, *Sampling Techniques*, third edition, Wiley Series in Probability and Mathematical Statistics, 1977, p. 165–167.

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

where

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

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

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

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

$e_{kl}$  represents the dollar value of error on the  $l$ th case in the  $k$ th stratum,

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

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

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

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

and

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

where

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

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

$P_S$  are the total projected payments from major strata  $S$ .

Then,

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

For FY 2007, the sample of cases will be drawn over a nine month period. The index of strata, "a," is 27, and the upper value for the index for months, i, is 9. The use of data over nine months rather than 12 months assumes that the active case payment error rate in the first quarter of FY 2007 (the omitted quarter) does not differ systematically from the error rate in the last nine months of the year.

Then, estimated variance is given by

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

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

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

## 5.2. Calculating Active and Negative Case Error Rates

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

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

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

where

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

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

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

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

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

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

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

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

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

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

where

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

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

$m$  is the sample size.

The sampling variance of this estimator is

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

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

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

## 6. Reporting

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

- By November 15, 2006, a Medicaid sampling plan and a SCHIP sampling plan for CMS approval, based on the universes of beneficiaries in the program and persons whose benefits were denied or terminated.
- By February 15, 2007, and then on the 15<sup>th</sup> of each subsequent month, (and before the reviews commence) monthly sample selection lists detailing the active and negative cases selected for review (from the previous month's universe).
- By the 150<sup>th</sup> day of the end of each sample month, the detailed eligibility findings based on 100 percent of the eligibility reviews.
- Within 60 days after the first day of the month in which the claims collection process begins, the payment review findings on each sampled case, that is, 210 days of the end of the sample month for 100 percent of the cases reviewed in that month.
- By July 1, 2008, summary eligibility and payment findings and the eligibility error rates for each program.

If the due date falls on a weekend or a Federal or State holiday, the due date is the next business day.

### 6.1. Sampling Plan

The sampling plan, which must contain the information shown in Exhibit 6.1, is due by November 15, 2006. Note that the number of cases to be sampled in each stratum each month must be consistent with those described in Section 2 Sampling. The sampling plan should be signed and dated by an appropriate State official.

Exhibit 6.1: Sampling Plan Content

<p><b>Eligibility Sampling Plan for [State] Program: [Medicaid or SCHIP] Fiscal Year 2007 Independent Entity [Agency]</b></p>
<p>The State must identify the agency and personnel or contracting entity responsible for eligibility reviews in its sampling plan with a stated assurance that the agency is independent of the State agency responsible for eligibility determination and enrollment or that the contracting entity is independent of the State's eligibility and enrollment activities.</p>
<p><b>Active Cases</b></p> <ol style="list-style-type: none"><li>1. Description of the universe for active cases.</li><li>2. Description of the strata for active cases.</li><li>3. Description of the following:<ol style="list-style-type: none"><li>a. how the monthly sample will be drawn;</li><li>b. how cases will be selected including the method used to randomly select cases;</li><li>c. the number of cases that will be over sampled to account for fraud cases inappropriately included in the sample.</li></ol></li><li>4. The quality control procedures that will be applied including procedures to ensure completeness of the population from which the sample is drawn.</li></ol>
<ol style="list-style-type: none"><li>5. Description of how records of claims and managed care payments associated with the cases sampled will be obtained.</li><li>6. Projected monthly sample size for each stratum.</li><li>7. Description, and underlying assumptions, regarding how the sample size was determined. If the sample size deviates from that recommended in this instruction due to the application of a finite population correction (i.e., the State's universe for the previous fiscal year is less than 10,000), a detailed explanation is required of how the alternative sample size was estimated and why it is likely to achieve precision requirements. Sample sizes that are less than the recommended sample size must be approved by CMS, based on the information in the sampling plan, prior to implementation.</li></ol>
<p><b>Negative Cases</b></p> <ol style="list-style-type: none"><li>1. Description of the universe for negative cases</li><li>2. Description of how the monthly sample will be drawn, the random method used to select cases, and the quality control procedures that will be applied</li><li>3. Projected monthly sample size</li><li>4. Description, and underlying assumptions, regarding how the sample size was determined. If the sample size deviates from that recommended in this instruction due to the finite population correction, a detailed explanation of how the alternative sample size was estimated and why it is likely to achieve precision requirements is required. Sample sizes that are less than the recommended sample size due to the finite population correction (i.e., the State's universe for the previous fiscal year is less than 10,000) must be approved by CMS, based on the information in the sampling plan, prior to implementation.</li></ol>

**6.2. Monthly Submission of Sampled Cases**

On completion of a sample for a given month, States must submit to CMS the list of cases sampled in each of the three strata for that month and the total number of cases in the universe for each stratum in that month. The same information must be submitted for the negative cases, for which there is only one stratum. See Exhibit 6.2 for an example of the reporting form to be completed and submitted to CMS by the 15<sup>th</sup> day following the sample month and before the reviews begin.

**Exhibit 6.2: Monthly Sample Selection List Report  
Payment Error Rate Measurement (PERM)**

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

Monthly Sample Selection List Report				
State				
Date				
Program				
Sample Month and Year				
	Stratum 1 Applications	Stratum 2 Redeterminations	Stratum 3 All Other Cases	Negative Cases
Number of cases in universe that month				
	Case/Beneficiary ID	Case/Beneficiary ID	Case/Beneficiary ID	Case/Beneficiary ID
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				



**Exhibit 6.3.2: Detailed Negative Case Review Findings Submission Report**  
 Due within 150 days from the end of the sample month.

Case/ Beneficiary ID	Sample Month	Denial or Termination D - denial T - termination	Review Finding C - correct ID - improper denial IT - improper termination	Cause of Error, if known

**Exhibit 6.3.3 Payment Review Findings Submission Report**  
**Payment Error Rate Measurement (PERM)**  
 Due within 210 days of the end of each sample month.

<b>Detailed Payment Review Findings Submission Report</b>	
<b>State</b>	
<b>Date</b>	
<b>Program</b>	
<b>Sample Month and Year</b>	

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

**6.4. Medicaid and SCHIP Error Rates**

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

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

**Exhibit 6.4.1: Summary Case Review Findings Submission Report**

**Payment Error Rate Measurement (PERM)**

Due July 1 following the fiscal year being measured.

Summary Case Review Findings and Error Rate Submission Report								
State								
Date								
Program								
	Total Number of Cases Sampled	Total Number of Cases Excluded due to Fraud	Total Number of Cases Eligible	Total Number of Cases Ineligible	Total Number of Cases Undetermined	Total Dollars Paid	Total Dollars in Correct	Total Dollars in Error
<b>Total</b>								
<b>Active</b>								
<b>Stratum 1</b>								
<b>Stratum 2</b>								
<b>Stratum 3</b>								
<b>Negative</b>								
<b>Denials</b>								
<b>Terminations</b>								

**Exhibit 6.4.2: Medicaid and SCHIP Error Rates Submission Report**

Summary Payment and Case Error Rates			
	Dollar Amount	Error Rate	Confidence and Precision
Active Payment Error Rate			
Active Case Error Rate			
Negative Case Error Rate			
Undetermined Cases		N/A	N/A

The active and negative case error rates, the variances and standard errors of the error rates, and a 95 percent confidence interval around that error rate will be calculated according to the methods described above and submitted to CMS's statistical contractor. CMS can provide an error rate calculator with instructions that States can opt to use to calculate the error rate. When the agency enters the data on eligibility review outcomes, the sample sizes, and the universe sizes, the spreadsheet will calculate the error rate, standard error of the estimate, and a 95 percent confidence interval. It will also calculate payment dollars in error for the active cases. States that choose to use this error rate calculator must submit a copy of the completed spreadsheet electronically to CMS' statistical contractor no later than July 1, 2008.

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

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

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

- Number of cases sampled,
- Number of cases in error, and
- Number of cases in the universe for that month.

The above information is sufficient to calculate the active case payment error rate (dollar weighted) and dollars in error and the active and negative case error rates (not dollar weighted), along with confidence intervals for the estimates.

## **Appendix A: Eligibility Review Process Timeline**

Version 09/28/06

FY 2007 Timeline for Medicaid and SCHIP Eligibility											
1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
October	November	December	January	February	March	April	May	June	July	August	September
	States submit Sampling Plans (11/15)	CMS works with States on Sampling Plans if needed	CMS approves plans (1/15)	Select January sample	Select February sample	Select March sample	Select April sample	Select May sample	Select June sample	Select July sample	Select August sample
Interim Final Rule effective (10/1)			States take actions to implement PERM eligibility reviews	Submit January sample list 2/15	Submit February sample list 3/15	Submit March sample list 4/16	Submit April sample list 5/15	Submit May sample list 6/15	Submit June sample list 7/16	Submit July sample list 8/15	Submit August sample list 9/17
				Begin January reviews	Begin February reviews	Begin March reviews	Begin April reviews	Begin May reviews	Begin June reviews	Begin July reviews	Begin August reviews
States design forms, staff-up, and begin other start-up activities.								Collect January claims	Complete January eligibility reviews	Complete February eligibility reviews	Complete March eligibility reviews
									Collect February claims	Collect March claims	Collect April claims
										Complete January payment reviews 8/15	Complete February payment reviews 9/17
										FY 2008 States submit sampling plans (8/1)	

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

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

## Appendix B: Glossary

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

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

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

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

**Beneficiary** – An applicant for, or recipient of, Medicaid or SCHIP program benefits.

**Case** – An individual beneficiary.

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

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

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

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

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

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

**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 or on a completed redetermination.

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

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

**PERM** – The Payment Error Rate Measurement process to measure improper payment in Medicaid and SCHIP.

**Payment review** - The process by which payments for services are associated with cases reviewed for eligibility. Payments are collected for services received in the review month or in the sample month, depending on the case reviewed.

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

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

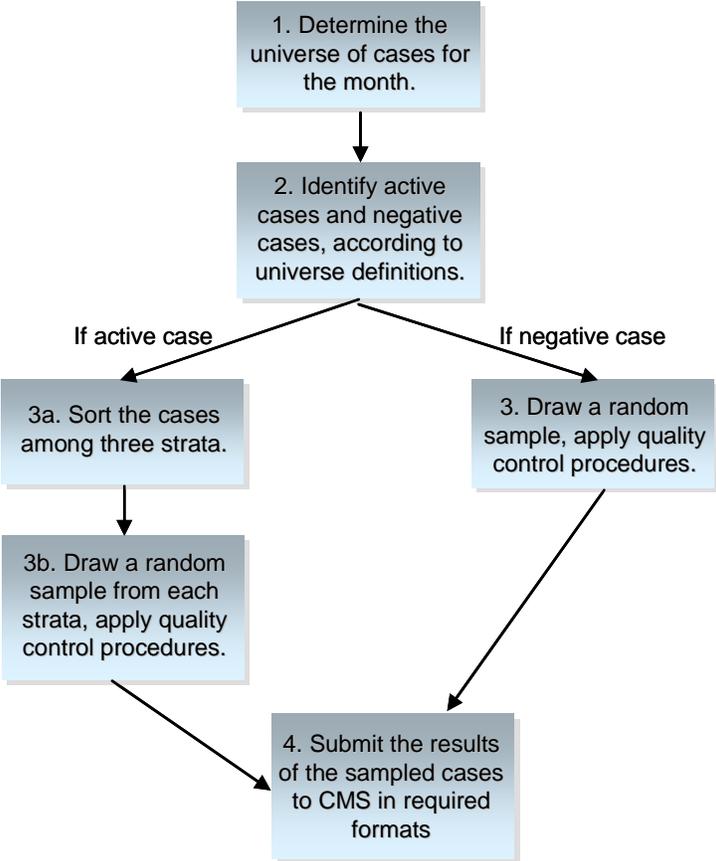
**State Agency** – The State agency that is responsible for determining program eligibility for Medicaid and SCHIP, as applicable, based on applications and redeterminations.

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

**Technical error** – Errors in eligibility which would not result in a difference between the amount that was paid and the amount that should have been paid (i.e., an improper payment) as described in Section 3.3.

**Undetermined** - A beneficiary case subject to a Medicaid or SCHIP eligibility determination under PERM about which a definitive determination of eligibility could not be made.

# Appendix C: Sampling Process



## Appendix D: Active Case Eligibility Sample Size

This appendix elaborates on the theory of sample sizes at the State-level for the dollar-weighted active case error rates.

### Eligibility Sample Size Calculation

The error rate estimate is given by

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

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

$P$  = total payments

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

For the eligibility category,

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

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

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

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

$\pi_i$  = Chance an observation in the i-th stratum is “in error”.

Then, the error rate can alternatively be written as,

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

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

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

Assume,

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

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

Now,

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

Then,

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

By Neyman-Pearson optimal allocation,

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

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

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

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

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

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

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

The margin of error,  $d$ , is thus

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

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

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

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

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

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

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

where,  $\xi = \mu_p^2 \sigma_x^2 + \sigma_p^2 \sigma_x^2 + \sigma_p^2 \mu_x^2$  (calculations for these formula could be done in the same way as the derivation shown in case of stratified sampling - simply consider  $i = 1$ ).  
Let the coefficient of variation (C.V) for payment be

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

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

For a simple random sample,

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

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

Hence,

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

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

Hence, for a simple random sample

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

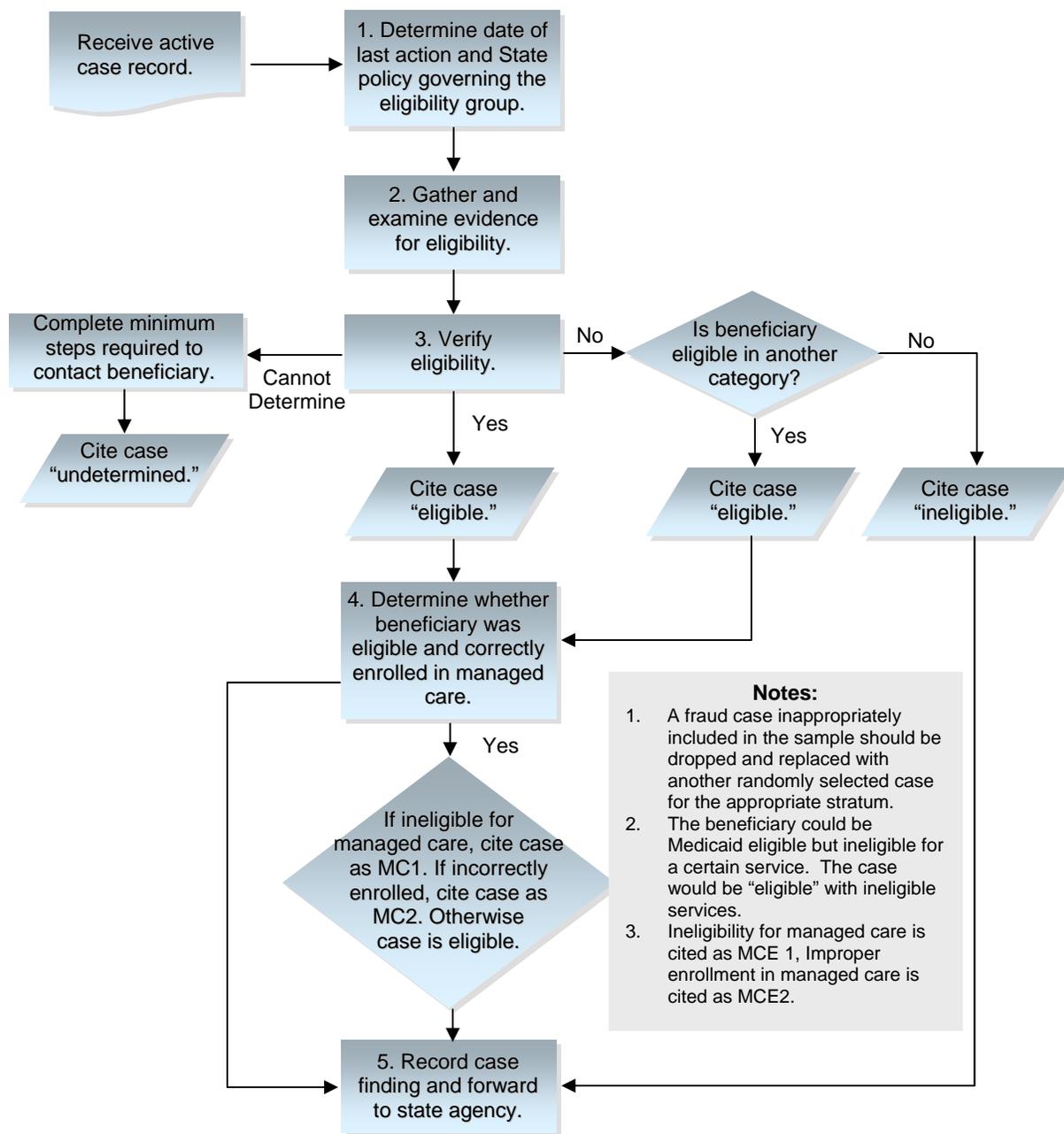
For IPIA requirement, to construct a 95 percent confidence interval for the error rate

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

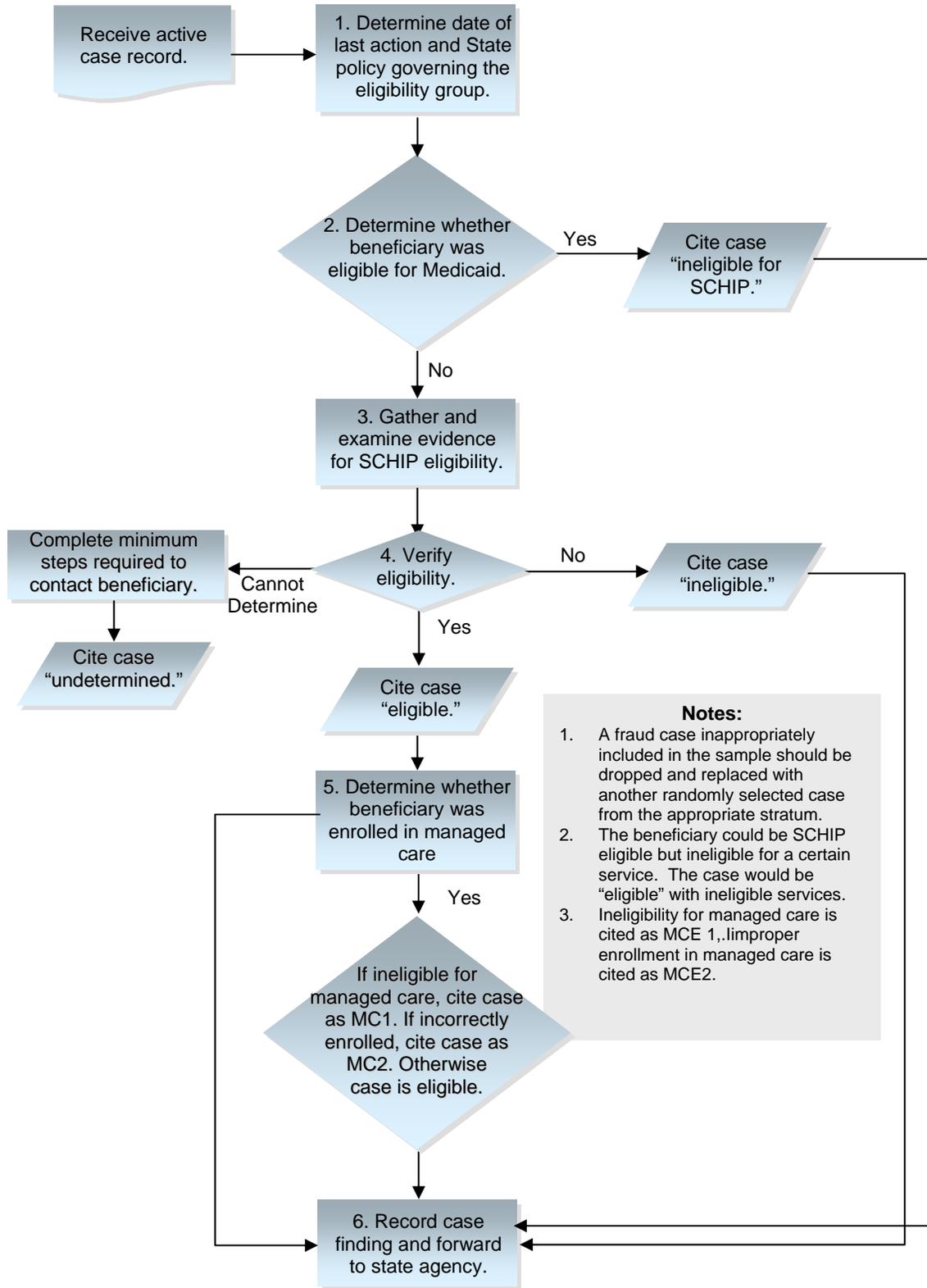
Note: Study on previous data (on PERM) shows that the coefficient of variation for payments is generally less than or equal 1 for all States.

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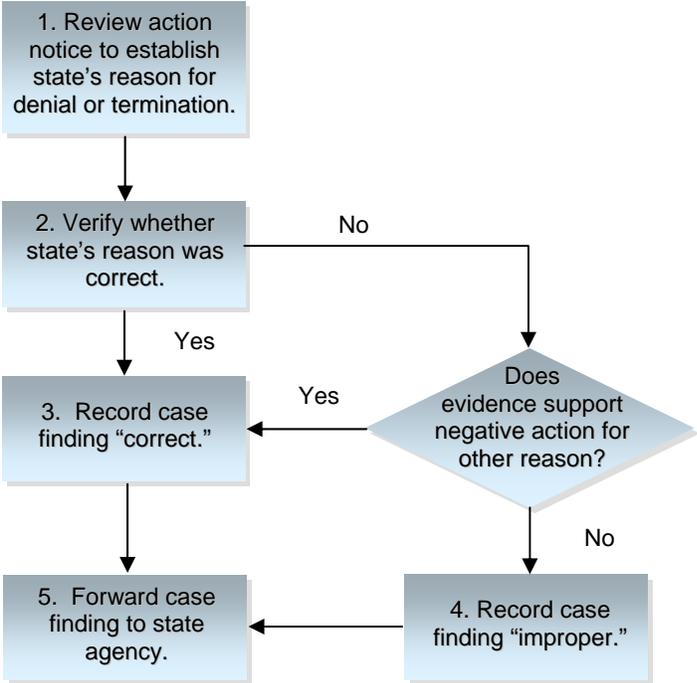
## Appendix E: Medicaid Active Case Review Process



## Appendix F: SCHIP Active Case Review Process



# Appendix G: Medicaid and SCHIP Negative Case Review Process



## **Appendix H: Reporting Forms**

[This will include the formal forms, once approved by OMB]