

Payment Error Rate Measurement Manual

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10 Payment Error Rate Measurement Program Introduction

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 Elimination and Recovery Improvement Act (IPERIA) (2012).

10.2 PERM Legislative Background

The Improper Payments Information Act of 2002 (IPIA), Pub. L. 107–300, enacted on November 26, 2002, required the heads of Federal agencies annually to review programs they oversee that are susceptible to significant erroneous payments. The IPIA directed the Office of Management and Budget (OMB) to provide guidance on implementation. OMB defined “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).

According to the OMB directive, Federal agencies must 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 and CHIP programs 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 Agency Financial Report (AFR). Through the Payment Accuracy Measurement (PAM) and PERM pilot projects that Centers for Medicare and Medicaid (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 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.

IPERA was further amended on January 10, 2013, by the Improper Payments Elimination and Recovery Improvement Act (IPERIA), Pub. L. 112-248. The aim of IPERIA is to further emphasize the importance of not only identifying and recovering improper payments but also to conduct the necessary analyses to reduce improper payments.

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' programs. 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 Fee-For-Service (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 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. 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 interim final rule and finalized State requirements for submitting claims to the Federal contractors 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 delays any calculation of a PERM error rate for CHIP until 6 months after the new PERM rule is effective. Additionally, the CHIPRA provides that States that were scheduled for PERM measurement in fiscal year (FY) 2007 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2007, or may elect instead to consider its PERM measurement conducted for FY 2010¹ 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

¹ Section 205(c) of the Medicare and Medicaid Extenders Act of 2010 exempted CMS from completing a FY 2009 or FY 2010 CHIP error rate. Therefore, for states that chose to consider FY 2010 as the first fiscal year for which PERM applies to the state for CHIP, FY 2013 will actually be the state's first CHIP PERM year.

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 is 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 provide States with the option to apply PERM data from eligibility reviews to meet 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 the 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 (spend down) or the amount of payment a beneficiary must make toward the cost of long term care, or in some instances, for home and community-based services.

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 individual or family 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 (Claims): Claims and payments where all services are paid with Title XXI funds, including Title XXI Medicaid expansion claims and payments (where beneficiaries are enrolled in Medicaid, but their claims and payments are matched with Title XXI funding) that are funded under CHIP.

CHIP universe (Eligibility): Cases where all services are paid with Title XXI funds, including Title XXI Medicaid expansion cases (where beneficiaries are enrolled in Medicaid, but their claims are matched with Title XXI funding) 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 Review Contractor's (RC'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 the Statistical Contractor (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 (HIPPP) 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 (Claims): Claims and Payments where all services are paid with Title XIX funds.

Medicaid universe (Eligibility): 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. There are also two optional Medicare parts: Part C (managed care) and Part D (prescription drug coverage).

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.

Patient liability: The term used by the Medicaid program to refer to the amount for covered services paid by the Medicaid beneficiary.

Payment: Any payment to a provider, insurer, or managed care organization for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP FFP. 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.

PERM Website: The official CMS website for the PERM program located at <http://www.cms.gov/PERM>.

PERM+: A claims and payment data submission method where the state submits claims, provider, and beneficiary data to the Statistical Contractor. The Statistical Contractor uses the data to build universes from which a random sample of claims is selected. After drawing the samples, the Statistical Contractor sends the samples to the Review Contractor and the States. The Statistical Contractor then populates the sampled FFS claims with detailed service and payment information and sends these samples to the Review Contractor.

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 42 CFR 431.960(c), 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 re-determine 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.

Routine PERM: A claims and payment data submission method where the state submits claims universes to the Statistical Contractor. The Statistical Contractor draws a random sample of claims from the quarterly universes submitted by the State. After drawing the samples, the Statistical Contractor sends the samples to the Review Contractor. The Statistical Contractor also sends the States a list of their sampled claims, and States populate sampled FFS claims with detailed service and payment information for the Statistical Contractor. The Statistical Contractor formats the State submissions and sends them to the Review Contractor.

Sample: A random sample of claims selected from a 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 42 CFR 431.960(b) and (d), 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, often called “kick” 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 (Claims): 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.”

Universe (Eligibility): The universe is the set of cases (individual or families) from which the sample for a particular program area is drawn and the set of cases for which the error rate is inferred from the sample.

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 and patient liability, 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 to 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 researching, requesting and collecting State medical and claims payment

policies from States requesting and receiving medical records from providers for sampled payments, and collecting claims payment policies, fee schedules and processing system manuals for conducting data processing and medical reviews, visiting state offices and/or providing web-based calls for orientation to the RC process. 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.

10.5.1 Statistical Contractor

The Statistical Contractor (SC) has three primary responsibilities: collecting and sampling claims and capitation payment data for review by the Review Contractor (RC), 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 FFP for Medicaid and CHIP services. The SC does a quality review of the data to ensure all claims covered by the PERM review are in the universe and that the claims data are properly formatted. 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 RC. The SC also sends the States a list of their sampled claims, and States populate sampled FFS claims with detailed service and payment information. After the samples are populated and returned to the SC, the SC standardizes the format of the FFS 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 PERM Eligibility Website 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.

10.5.2 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 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 17 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 and CHIP, so that each State is measured once every three years. At the end of each 3-year cycle, the rotation will repeat so that the FY 2012 States will be reviewed again in FY 2015; the FY 2013 States will be reviewed again in FY 2016; the FY 2014 States will be reviewed again in FY 2017.

CMS also calculates a rolling three-year national error rate, which is the official program error rate reported in the AFR.

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

Cycle	Includes Payments from These Fiscal Years	States
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 CMS Cycle Manager is assigned to each PERM cycle. This person serves as the States' main point of contact for that measurement, ensures the measurement timeline stays on track, and handles any issues that occur throughout a cycle.

10.6.1 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 Estimated Timeline

Timeframe	Event
July 1 (prior to federal fiscal year being measured)	PERM cycle begins
August 1	States submit eligibility sampling plans to the SC for approval
September 15	PERM Education sessions with CMS, SC, and RC begin States notify CMS and SC of method of PERM data submission (Routine PERM or PERM+)
October 1	State orientation meetings with CMS, SC, and RC begin
November 15	States select first monthly eligibility sample (for October) and begin reviews; subsequent samples submitted each month on the 15 th
January 15	States submit 1st quarter (October – December) adjudicated claims to the SC
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 SC
April - September	RC researches and obtains States' policies from relevant web sites.

Timeframe	Event
April	RC begins medical record requests when detailed data is 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 SC
September (last month of fiscal year being measured)	RC begins medical reviews
October 15 (following the fiscal year being measured)	States submit 4th quarter (July – September) adjudicated claims to the SC
October 15	States select final monthly eligibility sample (for September)
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 findings to the SC and the SC calculates the eligibility error rates for each State
July 15	Typical CMS cycle cut-off date
August	RC submits final findings to the SC SC calculates error rates
November (two fiscal years after the fiscal year being measured)	National rates published in Agency Financial Report States notified of state error rates and preliminary state-specific sample sizes for the following cycle
February	States submit Corrective Action Plans addressing identified errors
Throughout PERM process	States identify and resolve differences in review findings with the RC or through the State eligibility appeals process
One year from discovery of an overpayment	States return the FFP of identified FFS and managed care overpayments

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 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 (HIP) 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 IPERIA 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.

20.1.1 Date

PERM universes include claims and payments originally paid (or denied) only during the federal fiscal year under review. For example, for the FFY 2014 PERM cycle, the State’s PERM universe includes claims and payments originally paid between October 1, 2013 and September 30, 2014.

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 with the original paid amount provided. 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 20.3 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, 2013 for coverage in October 2013, a State being measured for the October 1, 2013 to September 30, 2014 measurement should include the payment, even though the State is purchasing coverage for a period outside the fiscal year being measured.

20.1.2 Program

OMB guidance on program payment error rate measurement directs DHHS to provide erroneous payment information under IPERIA 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, or would have been 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 (e.g., State-only or other federally-funded claims or programs) are excluded from the PERM measurement.

20.1.2.1 Title XIX/Medicaid

The PERM Medicaid universe includes payments matched with Title XIX funds. This includes claims for services provided to Medicaid beneficiaries.

20.1.2.2 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.

20.1.2.3 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.

20.2 Claim Types

IPERIA 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 fully adjudicated and are not included in the PERM universe. Rejected claims (e.g., claim batches rejected by a pre-processor for not conforming to 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 total computable paid amount.

20.2.1 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 cases, the single State agency or Medicaid or CHIP agency may make payments or transfers to another State agency or program on a capitated or per-member-per-month basis using either budgetary-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 are often non-risk capitated per member per month payments such as primary care case management (PCCM) payments to primary care physicians, disease management (DM) payments, and non-emergency transportation (NET) payments. Additionally, 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 eligible), certain reinsurance payments to managed care organizations, and drug administration capitations to nursing facilities are also included in PERM. 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.

20.2.2 Aggregate payments

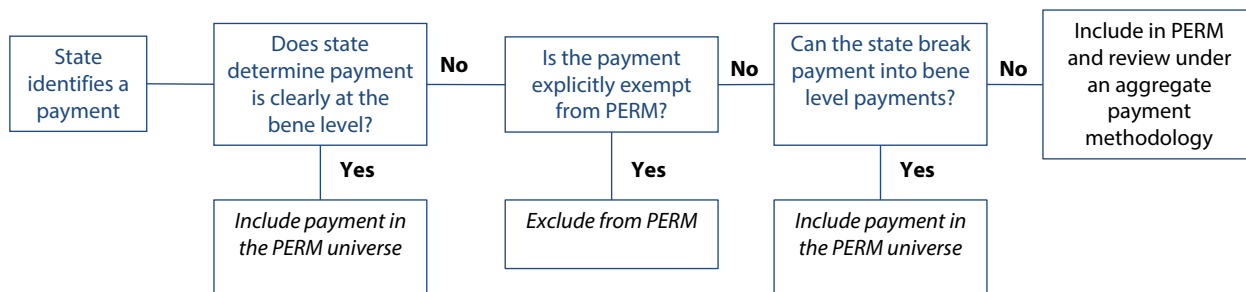
While most Medicaid and CHIP payments for services are paid at the beneficiary level, States also calculate and pay for some services on behalf of a group of beneficiaries. PERM broadly refers to these as “aggregate payments.” Unless otherwise specified by CMS, aggregate payments for services are included in the PERM universe. Aggregate payments are included in the PERM universe regardless of whether 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.

Aggregate payments lack fundamental consistency as payment methodologies and documentation varies significantly across States. To assist in handling aggregate payments consistently and appropriately within PERM, CMS developed a framework to include an aggregate payment in the PERM universe that follows the below decision tree:

Exhibit 3: Decision Tree to Help States Handle Aggregate Payments



Again, States should work with the SC and CMS to determine how payments should be submitted and reviewed for PERM. It is important to note that the definition of aggregate payments continues to evolve for PERM as states continue to develop innovative payment methodologies. CMS, the SC, and the RC will continue to evaluate which payments are considered aggregate payments for PERM. It is possible that an aggregate-type payment not included for PERM in a previous cycle could be determined to be an aggregate payment in a future cycle.

20.2.3 Exclusions

The PERM regulation explicitly excludes a small number of specific payment types from the universe. These typically do not represent payments for services provided 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, aka “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.

20.3 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, determines that the payment 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).

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.

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 reasons for mass adjustments are 1) changes in reimbursement rates to providers that cannot, for reasons beyond the control of the State agency, be implemented by their effective date or that go into effect on a retroactive basis, and 2) cost-based rates for which final cost settlements necessarily are completed, in some cases, years after the payments are made.

- ▶ *Changes in reimbursement rates to providers:* In some cases provider fee adjustments become 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.

A final example is rate or benefit changes that require CMS approval. 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 or change the rate methodology for certain types of services, it must 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.² 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 anticipation of a retroactive approval.

Note that if prices are changed retroactively but the changes are made outside of the 60-day adjustment timeframe, PERM does not consider it an error if the payment made was based on the pricing schedule on file at the time payment was made. Thus, if a State makes a payment according to an old payment schedule even though a new payment schedule is effective, whether because the effective date was retroactive (and therefore unknown when the payment was made) or because the system changes necessary to make the new payment could not be completed by the effective date, this will not be considered an error in the PERM review, even if the adjustment to correct the payment to the new, effective payment schedule is made more than 60 days after the paid date.

- ▶ *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.

As above, PERM will review the payment based on the pricing schedule on file at the time payment was made and will not consider it an error if prices are changed retroactively due to cost settlement but the changes are made outside of the 60-day adjustment timeframe.

² 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.

20.4 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.

20.4.1 General sampling unit definitions

For most individual beneficiary-level claims and payments the sampling unit is a claim, line item, financial transaction, 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 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, un-priced 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.

20.4.2 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 (TPL) 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, the RC and the State may need to work together to determine the appropriate sampling unit for aggregate payments and the appropriate review methodologies.

20.4.3 Adjustments

Each sampling unit must be included in the PERM universe once and only once. To avoid duplications of claims in the PERM universe, sampling units are 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.

20.5 Claims Sampling Process

Because it would be impossible to review the accuracy of every Medicaid and CHIP payment made to a provider or a 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 IPERIA 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. 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.

20.5.1 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 all of the four components (i.e., Medicaid FFS, Medicaid managed care, CHIP FFS, CHIP managed care), missing components are 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 the number of sampling units 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 the FY 2007 through FY 2010 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 4 below has the final base year PERM target sample sizes.

Exhibit 4: PERM Base Year Sample Size (Per State, Per Program Area)

Program Area	Base Sample Size	Additional Oversample	Total Base Year Sample
Base Year Quarterly Sample			
Medicaid FFS, CHIP FFS	125	5	130
Medicaid Managed Care, CHIP Managed Care	60	0	60
Base Year Annual Sample			
Medicaid FFS, CHIP FFS	500	20	520
Medicaid Managed Care, CHIP Managed Care	240	20	240

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 required 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 started on or after the date on which the final rule was 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), and the State-specific sample size provision went into effect with the FY 2011 PERM cycle.

The final rule established 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 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 estimates State-specific sample sizes for each program component within each State based on the prior cycle's error rate. The State-specific sample size must be sufficient to meet the precision requirements, which is to estimate the component error rate with a 95 percent confidence interval of 3 percentage points in either direction.

20.5.2 Fee-for-Service Claims Payment Stratification

PERM independently samples payments from four universes or program areas: Medicaid FFS, CHIP FFS, Medicaid managed care, and CHIP managed care.

A service-type stratification approach is used for the FFS sample. Strata within each state FFS universe consist of 11 service-type strata and one stratum for denied and zero-paid claims since the fourth quarter of the FY 2012 cycle. During the first three quarters of the FY 2012 cycle, there was not a separate stratum for zero-paid and denied claims.

Step 1: All payments in the FFS universe with a positive paid amount are assigned to one of the following 11 service categories:

- ▶ Inpatient Hospital
- ▶ Outpatient Hospital
- ▶ Long Term Care
- ▶ Physicians, Dentists, Other Practitioners
- ▶ Clinics
- ▶ HCBS/Rehabilitation/Hospice
- ▶ Lab, X-Ray, DME, Trans, Other Services
- ▶ Pharmacy
- ▶ Fixed Payment
- ▶ Medicare Crossovers
- ▶ Medicare Premiums
- ▶ Denied and zero-paid

The SC uses State claims and provider data dictionaries to determine how to assign State claims to the service strata. The SC works in close collaboration with the States during this process to determine the most appropriate assignment for each type of claim or payment States make. It is possible that for some States, a service stratum may not have any claims. This is more likely for CHIP where long term care claims and Medicare crossovers are very rare, but it can happen in Medicaid if a state does not make any fixed payments.

The claim categories used to stratify the samples are different from the categories used to categorize claims and payments for medical record review. Please refer to Section 70.1 for a listing of the claim categories used for medical record review.

Step 2: Within each service-type stratum, all lines are sorted from largest to smallest payment amounts.

Step 3: Most of service-type strata have a minimum sample size of 7 claims per quarter but the Medicare crossover, Medicare premium, and the denied and zero-paid strata will only have 5 claims each per quarter. This is a total of 78 claims. If the sample size is larger than 78 claims for a quarter, the remaining sampled claims will be distributed among the service-type strata proportionally based on the total dollars assigned to each stratum excluding the Medicare crossover, Medicare premium, and the denied and zero-paid strata. The total dollars in each stratum will differ, depending on the total dollars associated with that service type in the claims universe.

In those cases when a stratum does not contain any claims, the minimum sample size for the missing stratum is zero which reduces the number of sampled claims required to be assigned to a stratum and increases the number of sampled claims that can be distributed proportionally by the total dollars in each stratum.

During the first three quarters of the FY 2012 cycle, there was no denied and zero-paid stratum. Therefore, the minimum number of claims required to be sampled was 73 claims with the remaining sample distributed proportionally by the total dollars in each stratum.

20.5.3 Managed Care Claims Payment Stratification

A dollar-based stratification approach is used for the managed care sample. Each program area is divided into strata based on payment amounts. Any number of strata could be used; total payments are divided by the number of strata and an equal proportion of payments are included in each stratum. For example, if five strata were used, each stratum would contain 20 percent of total payments, but if ten strata were used, each stratum would contain 10 percent of total payments. The following example 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 total payments. This is the first stratum.

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

Step 5: This sequence is repeated until all five strata are constructed. The fifth stratum always contains all denied lines (denials are rare in managed care programs, but do occur in some States). 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 are 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 5* below.

Exhibit 5: Stratification by Expenditures—Five Strata Example

	Stratum 1	Stratum 2	Stratum 3	Stratum 4	Stratum 5	Strata
	<i>(Largest claims)</i>				<i>(Smallest, denials, zero paid)</i>	<i>All</i>
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

If ten strata are used, each stratum will include 10 percent of the dollars in the universe. Payments would be sorted and applied to each stratum in the same manner, so that a small number of high-dollar payments would be placed in the first stratum, and a large number of very small payments would be placed in the last stratum.

20.5.4 Claims Payment Sampling Process

The general process used to develop the sampling strata and extract the sample for one quarter for one program area is summarized below.

Step 1: Define strata (by service type for FFS or paid amount for managed care) and sort all lines into the appropriate stratum.

Step 2: Sort all lines in each stratum 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: 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, and n_i denotes the number of claims in the sample for the i^{th} stratum in a State.

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

Step 4: Determine a random start value for each stratum (denoted by $start_i$), such that $1 \leq start_i \leq k_i$ (i denotes the i^{th} stratum).

Step 5: Sample every k_i^{th} item within the i^{th} stratum.

20.5.5 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 is created using replacement data provided by the State.

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

Step 3: All lines in the original sample that exist in the corrected universe file are left in the corrected sample, if it is 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 the valid portion of the original sample, is done from the corrected universe file.

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

Step 6: The sampling procedure described in section 20.5.4 is applied to the additional sampling from the corrected universe file.

Following these steps ensures the sample remains a simple random sample within strata and that accurate sampling frequencies can be calculated so that the population inferences remain unbiased. There might be cases where this process results in more than the required number of lines in a stratum due to the reallocation of the sample prescribed by the corrected universe file.

20.6 PERM Data Submission

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

20.6.1 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. The second data submission contains claim detail files for those FFS payment records that were selected for audit, after the PERM contractor has sampled from the universe files. Typically, States must exchange data several times with the SC to populate sampled claims with the details required for medical record requests and claim processing reviews.

Please reference the cycle tabs on the PERM website for the routine PERM data submission instructions for each cycle.

20.6.2 PERM+

PERM+ is a data submission process developed by CMS to simplify PERM for States. Through PERM+, States submit claims, recipient data, and provider data at the beginning of each quarter. The SC, not the State, is responsible for much of the data programming to develop a PERM universe. The SC develops “sampling units” (i.e., determines whether a claim or payment should be sampled at the header or line level based on the payment method, and removes records that don’t qualify for sampling). States submitting under PERM+ do not have to develop the sampled claim detail information, as the SC will be responsible for merging provider and recipient information into the sampled claims.

Each State, in conjunction with CMS, decides if data will be submitted via the PERM+ method prior to the SC’s intake meeting with each State. States must notify CMS by September 15 prior to the Federal fiscal year being measured if they will use PERM+ to submit some or all of their data.

Please reference the cycle tabs on the PERM website for the PERM+ data submission instructions for each cycle.

20.6.3 Claims Data Submission Due Dates

States submit claims and payment data for routine PERM and PERM+ on a quarterly basis. Data are due to the SC 15 days after the end of each quarter as shown in Exhibit 6, unless the due date falls on a weekend or federal holiday, in which case the due date is the next business day.

Exhibit 6: 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 – September 30	October 15

20.6.4 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 the Data Submission Instructions on the CMS PERM Website for claims data quality review instructions and guidance on comparing PERM data to CMS Financial Management Reports.

The SC will perform a data quality review as well on claims and payment data submitted by States. Occasionally, the SC may submit questions to the States to resolve issues identified with the data. States are expected to respond promptly to any data quality questions submitted to them by the SC.

20.6.5 Data Security

Under PERM, States submit documentation that contains protected health information (PHI), which includes individually identifiable health information (IIHI), and personally identifiable information (PII) for purposes of medical reviews and data processing reviews on paid claims and for eligibility reviews. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CMS, its contractors, and States are all responsible for ensuring the security of PHI and PII 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 or PII prior to transmission and that any passwords are sent securely and separately from the transmitted data, regardless of the method of transmission. PHI or PII should never be sent by email.

Under HIPAA, covered entities must ensure the secure transfer of PHI and PII contained in any data transmissions. To meet this requirement, CMS requires all State data transfers containing PHI and PII 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.³ 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 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 PHI or PII, 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 2009.⁴

The CMS contractors will provide States with instructions on data submission that meet CMS security requirements. If a State will require a Data Use Agreement (DUA) with a PERM

³ 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>

⁴ 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 accessed at: <http://ftc.gov/healthbreach/>.

contractor prior to submitting data or allowing system access for payment reviews, the draft DUA must be submitted to CMS for review by October 1 at the beginning of the cycle. CMS will forward the DUA to the appropriate contractors for review and approval. The terms of a DUA will be negotiated between the State and the PERM contractor.

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 the 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 an eligibility intake teleconference between the State, CMS, and the SC prior to plan approval where the CMS and the SC will walk the State through a series of questions related to the State’s process for conducting the PERM eligibility measurement. 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 2014)
- ▶ Name of independent agency or contractor responsible for PERM eligibility reviews
- ▶ Name, phone number, and email address of person responsible for answering questions relating to the sampling plan
- ▶ Description of the eligibility appeals process that will be employed by the State
- ▶ List of the agencies in the State that make eligibility determinations and a State agency contact responsible for overseeing eligibility appeals (if applicable)
- ▶ Whether or not the State has self-declaration or simplified enrollment policies and under what circumstances self-declaration is acceptable
- ▶ Description of MEQC activities for the concurrent 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
 - ❑ Description and explanation (if necessary) of exclusions from the active case universe for Medicaid and CHIP, including how cases under beneficiary fraud will be addressed and that cases enrolled in Medicaid or CHIP using Express Lane Eligibility are excluded (if applicable)
- ▶ Description of Stratum (if applicable)
- ▶ Sampling unit chosen (individual or family)
- ▶ 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 and the time period for which they will be obtained
- ▶ Description of the negative case universe and sampling process

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

Please reference the PERM Eligibility Review Guidance on the CMS PERM Website for a Sampling Plan Template Outline.

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. The universe should also include cases for which any State agency, in addition to the primary State agency responsible for eligibility determinations made a decision to either grant eligibility or deny or terminate eligibility for Medicaid or CHIP.⁵ 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).

The PERM eligibility sampling unit is referred to as a “case” and is defined as an individual or family. Note: A “family” may include just one beneficiary. States have the option to choose the sampling unit, either individual or family (e.g., assistance unit, assistance group, etc.).

States that sample at the individual beneficiary level will 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. Sampled cases will be reviewed for all eligibility categories for which the case was deemed, e.g., a long term care Medicaid recipient

⁵ Please see 80.14.2 – 100 percent Federally funded cases.

that is enrolled in Qualified Medicare Beneficiary (QMB) must have the long term care and QMB determinations reviewed for eligibility.

30.2.1 Active Case Sample

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

30.2.1.1 Identifying the Active Case Universe

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

Exclusions from the active case universe are:

- ▶ All cases that were denied or terminated (Note: These cases should be included in the negative case universe)
- ▶ Cases under active beneficiary fraud investigation (as defined in section 10.4)⁶
- ▶ 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)⁷
- ▶ For Medicaid only, Supplemental Security Income (SSI) cash cases in States with an agreement with the Social Security Administration (SSA) under section 1634 of the Social Security Act
- ▶ For Medicaid only, adoption assistance and foster care cases under Title IV-E

All other cases in which services are matched with either Title XIX or Title XXI funds should be included in the active case universe. Cases still on the program pending the required ten day notice of termination and cases where benefits are properly being continued pending an appeal of termination should be included in the active universe.

30.2.1.2 Spend Down Cases

Spend down cases occur when a beneficiary’s excess income must be offset with incurred medical expenses to gain eligibility. Depending on how each State captures spend down case information, there may be a different method for how to address them in the PERM universes.

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

⁶ If a case is terminated due to a final determination of beneficiary fraud, it should be placed in the negative case universe and will be considered a correct termination.

⁷ Coding is only required for cases enrolled using Express Lane Eligibility (ELE). Active cases that do not meet the necessary thresholds to be enrolled under ELE should appear in the PERM and MEQC active case universes.

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

Active without receiving benefits: For States that capture spend down cases as active cases that are not receiving benefits, these cases should be included in the active universe for sampling and review according to the guidelines presented in section 5 of the PERM *Eligibility Review Guidance for Medicaid and CHIP Benefits* document. Cases will be reviewed to ensure the accuracy of the calculated spend down amount, but may have no payment dollars collected if there were no services received in the sample month matched with Title XIX dollars.

30.2.1.3 Sample Size for Active Cases

Sample sizes must be sufficient to meet the precision requirements, which is to estimate the active case payment error rate with a 95 percent confidence interval of 3 percentage points in either direction.

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

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

States in the base year will sample 42 cases each month for the 12-month Federal fiscal year (i.e., 504 cases/12 months). In subsequent cycles of PERM reviews, an equal number of cases should be sampled in each month, although the annual total may differ from the base year. In addition to selecting an equal number of cases each month, States also need to select an equal number of cases from each active case stratum, if applicable.

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).

30.3 Method for Drawing the Monthly Active Case 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 that States can use to draw a random sample: simple random sampling or the "skip" factor method.

- ▶ For *simple random sampling*, States should assign each case an integer from 1 to n , where n is the number of cases in the universe. Then, using a program that has a random number generator, such as Statistical Analysis Software (SAS), randomly generates 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 each month by the required monthly sample size. This number becomes the "skip" interval or n . Randomly select a number from 1 to n for the starting point in the universe using a program that has a random number generator (e.g., SAS). Select that case and then every n th case until the required sample size is met. For example, if the number of cases in the universe is 1,000, and a sample size of 20 is needed, the skip interval would be 50. A random integer would be generated between 1 and 50 (inclusive of the end points). If this random number was 7, then, sample case number 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 section 30.4.6 - Adjustments to the Monthly Sample, States may want to draw an oversample in case any problems are discovered in the sample (e.g., active beneficiary fraud).
- ▶ When using the "skip" factor method of sampling, the State has two options for selecting the oversample.
- ▶ The State may draw an initial sample that has a sufficient number of cases for the sample and oversample, and then randomly select the cases which will be considered the oversample cases. (Note: Taking the first two or last two cases as the oversample is not random.)
- ▶ Alternatively, the State may conduct a second systematic random sample to select the oversample but would first need to remove the cases that were initially sampled from the universe used to select the oversample.

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

30.4 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.

30.4.1 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. Denied cases should be placed in the negative universe in the month the decision to deny was made (e.g., a case would be in the negative universe in November if the application was denied in November). Terminated cases should be placed in the negative universe in the month in which the termination takes effect (e.g., a case would be in the negative universe in November if the last date of eligibility is October 31 and therefore the effective date of termination is November 1).

Exclusions from the negative universe include:

- ▶ Cases still in the program pending the required notice of termination
- ▶ Cases that have a termination action but are still active until the end of the certification period
- ▶ Cases where benefits are properly being continued pending an appeal of termination, are excluded from the negative universe (and should be placed in the active universe).
- ▶ State-only funded cases

30.4.2 Sample Size for Negative Cases

The base year sample size (i.e., the sample size to be used by States in their initial year conducting PERM eligibility reviews) of 204 negative cases is required in order to obtain a negative case error rate with a 95 percent confidence interval of 3 percentage points in either direction..

After the base year, if the State's negative case error rate is below 5 percent, a smaller sample size may be sufficient to achieve the desired precision requirements. Similarly, States with negative case 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 cycle negative case error rate. CMS has established a maximum sample size of 1,000 negative cases, regardless of a State's eligibility error rate in the prior cycle.

States in the base year will sample 17 cases each month for the 12 month Federal fiscal year (i.e. 204 cases/12 months). In subsequent cycles of PERM reviews, an equal number of cases should be sampled in each month, although the annual total may differ from the base year.

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

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

30.4.3 Method for Drawing the Monthly Sample

States will draw monthly samples from this universe of negative cases over the entire twelve months of the Federal fiscal year.

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 submit it to CMS. The methods for drawing the negative case sample are the same as the methods described in section 30.3.

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

30.4.4 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.

30.4.5 Timeframe for Creating the Monthly Active Case Universe

The active and negative case universes should be considered a “snapshot in time”. For States that are not employing stratification in the active case universe, the last action completed on a case and the date the universe is generated determine if cases are correctly included in the active or negative case universes. Any actions that occur after the date the universe is generated are not considered during the sampling or review process. Below is an example of when the “snapshot in time” plays a role in the sampling and review process.

Example 1: The universe for October is created and the sample is drawn November 3rd. A case that was terminated on October 31st was reinstated on November 5th with retroactive coverage back to November 1st. Since the reinstatement would not be captured in time for the sample pull, the case is negative for October and active in November.

Example 2: The universe for October is generated and the sample is drawn on November 10th. A case was reinstated on November 5th with retroactive coverage of November 1st. The reinstatement is captured in time for the sample pull and therefore the case is active in both October and November.

30.4.6 Adjustments to the Monthly Sample

If a State discovers a sampled case should not have been included in the Medicaid or CHIP eligibility universe or a State identifies a problem with the Medicaid 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 there are issues with the sample due to incorrect universe specifications (e.g., cases were incorrectly included or excluded

from the universe prior to sampling), the SC will also need information regarding the number of affected cases in the sample as well as the potential impact of those cases on the submitted universe totals (e.g., how many cases were incorrectly included/excluded from the universe). States will also need to resubmit a revised sample list to the PERM eligibility review tracking website, if the issue is identified after the initial sample has been submitted.

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

- ▶ A case is found to be under active beneficiary fraud investigation
- ▶ A case that should have been excluded from the sampling universe was inadvertently included in the universe and sampled (e.g., a State-only case was sampled)
- ▶ A case was enrolled in Medicaid or CHIP using States' Express Lane Eligibility 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.

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

States may also consider capturing and storing the monthly universe information. This may assist them when attempting to isolate problems as they occur and still have access to the same universe information as it appeared at the time the universes are generated.

Note: States may not withhold monthly samples based on the need for correction of identified sampling problems without consulting the statistical contractor. States must allow the statistical contractor to assess any revised approaches to making corrections to the universes or samples.

30.5 MEQC/PERM Substitution

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

will constitute a “traditional” MEQC review. Below are the conditions that must be met in order to employ one of the substitution options.

30.5.1 Develop a Sampling Plan

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

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

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

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

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

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

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

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

30.5.2 Review Requirements

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

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

30.5.3 Substituting MEQC reviews

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

review finding; see Exhibit 7. Complete the payment review process as described in at **section 80.6 - Payment Reviews**.

Exhibit 7: PERM Eligibility Review Finding Definitions

Finding	Definition
E	Eligible
EI	Eligible with Ineligible Services
NE	Not Eligible
L/O-SD	Liability Overstated – Spend Down
L/O-BP	Liability Overstated – Beneficiary Premium
L/O-O	Liability Overstated – Other
L/U-SD	Liability Understated – Spend Down
L/U-BP	Liability Understated – Beneficiary Premium
L/U-O	Liability Understated – Other
MCE1	Ineligible for Managed Care
MCE2	Eligible for Managed Care, but improperly enrolled
U	Undetermined
TE-ACT	Active Case Technical Error
C	Correct (Negative Case)
ID	Incorrect Denial (Negative Case)
IT	Incorrect Termination (Negative Case)
TE-NEG	Negative Case Technical Error

30.5.4 Modified MEQC Review Requirements

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

The Modified MEQC review includes:

1. Case Record Review

A case record is defined as either a hard copy or electronic file that contains information on a beneficiary regarding program eligibility. The case record could include copies of official documents, written caseworker notes and worksheets (e.g., initial application, verification checklist), electronic documents pulled from other sources, electronic case notes from the eligibility worker documenting their actions, etc. Analyze the case record to identify gaps in required documentation or deficient information in the review month based on missing documentation or misapplied State and Federal policy.

2. Field Investigation

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

3. Assign Error Findings

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

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

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

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

30.5.5 Substituting PERM Reviews

Review each case in accordance with the PERM Eligibility Review Guidance and assign each case the appropriate PERM finding. The use of the PERM reviews will serve as a “traditional” MEQC review.

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

The August 2007 PERM final rule made effective the option for States to use PERM negative case reviews to comply with the negative MEQC case action review requirements. The process for using the PERM negative case reviews to complete the MEQC negative case action reviews will remain the same. A State does not have to substitute active case data to use this option. Please see [section 30.1.2-Negative Case Sample](#).

30.5.6 PERM & MEQC Payment Reviews

The process for completing the PERM and MEQC reviews remains the same, with the caveat that States using the MEQC review process may not apply error dollar tolerance to their payment reviews.

States will wait five months following the sample month before identifying claims for services received in the sample month. Claims for services received in the sample month are identified and associated with a case in accordance with the States' policy on effective date of eligibility, either full month or date-specific eligibility. See Exhibit 8 for an example of the payment review process. The example illustrates the timeframe for identifying a payment for a service received for a case sampled in October. Based on the eligibility review finding, verify whether the identified payments were made appropriately. Report the correct payments, improper payments and payments associated with undetermined cases for each sample month.

Exhibit 8: PERM Payment Review Process Example

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

For the general step-by-step process to complete the eligibility payment reviews, including specific payment review situations, please see [section 80](#) — Eligibility Reviews.

30.5.7 Error Rate Calculation

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

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

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

30.5.8 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.

30.5.9 Reporting

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

40 State Policy Collection Process

The RC is responsible for acquiring Medicaid and/or CHIP policies for each State selected for review for the PERM cycle. The RC is also responsible for maintaining a database that contains a complete set of policies for each selected State governing their respective Medicaid and/or CHIP programs and the 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 and CHIP 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 PERM RC's website where States can track medical record requests is included on the website's homepage.

50.1 Provider Contact Validation

By referencing sampled claims, the RC first verifies the provider information by contacting either the performing provider or the billing provider by phone, using contact information provided 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 State's claim files after using other means (e.g., internet, directory assistance), the RC will contact the State to obtain more current provider information.

50.2 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 records and patient information is not a violation of HIPAA standards. The RC customer service representative's telephone number and the provider's State Medicaid representative's telephone number is included if the provider requires additional information or has questions.

The letter package includes a claim summary with 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 package also includes a PERM Fax Cover Sheet that 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 calendar days from the issue date of the letter to provide the requested medical record to the RC. The last enclosure of the letter package includes instructions for providers' submission of medical records to the RC. Records may be submitted by the United States Postal Service, a toll free fax number, CD, or electronic submission of Medical Documentation (eMD) to the RC. For more information about esMD, see www.cms.gov/esMD.

50.3 Follow-up Medical Record Requests

The RC will contact each provider who has not submitted the requested record information by telephone. The RC will make up to three additional calls at 30, 45 and 60 calendar days from the initial request 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. The letter also informs the provider that failure to submit the requested medical record resulted in a PERM error and that a notice of the error will be submitted to State officials who may seek recoveries for claims in which medical records are not received by the RC in a timely manner.

50.4 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 calendar 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 14 calendar 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 information request. The letter 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.

50.5 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 to the cycle cut-off date for error rate calculation and reporting purposes (generally the second July 15 of a measurement cycle), it will review the records and, if justified, revise the error finding.

If late documentation is received after the cycle cut-off date, the documentation will be reviewed under continued processing only.

50.6 Policy for Handling Lost or Destroyed Documentation

The PERM measurement involves the review of documentation in support of paid FFS claims in the Medicaid and CHIP programs. Providers are contacted and requested to submit documentation for review of their claims. A provider may be unable to provide documentation due to its loss or destruction from a natural disaster such as a flood, hurricane, earthquake or tornado, and in cases of destruction by fire. In the event of a Federal Emergency Management Agency (FEMA) declared disaster, the SC will drop the claim from the sample, and replace the claim with another randomly sampled claim if time allows. Determinations in the event of a fire will be made on a case-by-case basis.

50.6.1 Provider Attestation

The PERM RC sends requests for medical records/documentation to a provider to complete a medical review. If a provider is not able to supply the documentation due to loss or destruction from a disaster, the provider should submit an attestation statement by fax or mail to the RC within 75 days of the date of the initial written request for documentation from the RC.

50.6.2 Re-Sampling or Excluding Claims

In the event a provider’s documentation has been lost or destroyed in a FEMA declared disaster, the sampled claim will be replaced with another randomly sampled claim from that State’s universe for the PERM review. In the event re-sampling is no longer possible due to timeline constraints, the SC will discard the claim(s) from the sample.

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:

60.1.1 Verification of Beneficiary Information

In order for the RC 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 (aid category/benefit plan) and effective dates (relative to dates of service) reviewed in MMIS system and may also be reviewed in the state eligibility system or through reports from that system
- ▶ Beneficiary residency or population requirement for enrolling in a managed care plan, or living in a mandatory managed care geographical area

60.1.2 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.

60.1.3 Verification of Provider Eligibility

In order to verify that the provider(s) (including billing, attending/servicing and ordering/referring providers) 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, including verifying a provider is not listed on the Office of Inspector General (OIG) excluded providers list (LEIE)

60.1.4 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:

- ▶ Claim filing date and filing timelines applicable to that claim/provider type.
- ▶ Service coverage policies are checked to assure the service provided includes a prior authorization (PA) if required, the PA limits (dollar amount, number of units and dates in effect) have not been exceeded by the paid amount, and the proper fee schedule in effect was used for the date of service.
- ▶ Duplicate payment history.
- ▶ Adjustments to the sampled claim.

Note that in order to complete these aspects of the review, the reviewer may need access to screens containing information on National Drug Codes (NDC), revenue codes, procedure codes, payment rates, and pricing schedules (e.g., DRG, per diem, max fee, provider specific), for all types of claims. The reviewer may need to access rates for older dates of service and 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. Information about how the State calculates each type of payment may be required. 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. The reviewer may need access to other claims in the system in order to conduct a check for duplicates. If the provider filed a hard copy claim, access to the scanned image of the claim as well as the system information is required. Finally, the reviewer may need access to tables that explain codes used in the system (if this is not contained in the system help).

60.2 Basic Managed Care Data Processing Review Components

60.2.1 Verification of Beneficiary Information

In order for the RC 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 (aid category/benefit plan) and effective dates (relative to dates of service) reviewed in MMIS system and may also be reviewed in the state eligibility system or through reports from that system

60.2.2 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

60.2.3 Correct Payment

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

60.2.4 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). Conflict duplicates may also be identified.

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. Also includes providers who are not enrolled, licensed or otherwise eligible to provide and bill for services on the date of 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 deficiency was found during data processing review that did not result in a payment error.

C1 - No Error: The claim was reviewed and no errors or deficiencies were found.

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 dollar measure of the payment error is 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.

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, aggregate payments, other PERM fixed 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. States can track medical-review findings using the PERM RC's website. The homepage of the PERM RC's website includes a user's guide.

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: Hospital (non-mental health)

- ▶ Acute Inpatient
- ▶ Acute Outpatient
- ▶ Long Term Acute
- ▶ Acute Inpatient Rehabilitation
- ▶ Emergency Services

Claim Category 2: 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, or Intermediate Care Facilities (ICF)

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

Claim Category 4: Intermediate Care Facilities (ICF) for Intellectually Disabled and ICF Group Homes

Claim Category 5: Clinic Services

- ▶ Federally Qualified Health Centers (FQHC)
- ▶ Indian Health Service Outpatient
- ▶ Rural Health Clinic (RHC)

Claim Category 6: Physicians, Physician Clinics, and Other Licensed Practitioners' Services (Includes Nurse Midwife and Midwife 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 and 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

- ▶ 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, occupation, and respiratory
- ▶ Services for speech, hearing, and language disorders
- ▶ Necessary supplies and equipment

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

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

Claim Category 17: Transportation and Accommodations

Claim Category 99: Unknown

The following claim categories do not require medical review:

Claim Category 18: Denied Claims

Claim Category 19: Medicare Crossover Claims

Claim Category 30: Capitated/Fixed Payment Claims

Claim Category 50: Managed Care Payments

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.

70.2.1 Verification of Documentation Sufficiency

In order for the RC 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.

70.2.2 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.

70.2.3 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.

70.2.4 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 RC 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?
- ▶ 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)?
- ▶ Would another procedure code be more appropriate?

70.2.5 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

70.3.1 Underpayments

If reviewers note a discrepancy between the number of units billed and the number of units provided, they should verify whether there was 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.

70.3.2 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 does 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 does 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.

70.3.3 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 or CHIP 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.

C1 - No Error: The claim was reviewed and no errors or deficiencies were found.

In some cases, it may be difficult to distinguish between insufficient documentation errors (MR 2) and policy violation errors (MR 8). Exhibit 9 outlines examples of the guidelines the RC will follow to assign these errors properly and consistently.

Exhibit 9: 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.

While reviewing this guidance, particularly in [section 80.2](#) Process for Verifying Active Case Eligibility, please ensure that PERM reviewers are reviewing cases based on the instructions in this document in conjunction with Federal regulations and guidelines, the CMS approved State plan and written State policies and procedures. If the State plan or State policies are silent, defer to Federal laws and regulations, including guidance in the State Medicaid Manual, State Health Official letter or State Medicaid Director letter.

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

Please note that if a State is sampling at the individual beneficiary level, review all eligibility categories associated with the case, e.g. a long term care Medicaid recipient that is enrolled in QMB must have the long term care and QMB cases reviewed for eligibility. States sampling the family must review each member of the group and all associated categories.

80.1 Eligibility Reviews

80.1.1 Review Month

For PERM purposes, the review month is the month when the State’s last action occurred and should be the month for which eligibility is verified. The last action could be an annual or semi-annual redetermination or any change captured in the system that results in a redetermination of eligibility. For retroactive cases, the review month is the month that the decision was made for retroactive coverage and could be a month after the sample month. There is no administrative period for the PERM eligibility reviews.⁸

An exception to verifying eligibility as of the review month occurs 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. This does not apply to instances in which a State grants prospective eligibility to make a determination or conducts an eligibility redetermination ahead of schedule, e.g. CHIP redeterminations for prospective eligibility.

Example 1: A case is sampled in January 2012. The State’s last action occurred in May 2011. Eligibility for this case is verified as of May 2011 (the review month) because it occurred within the past 12 months.

⁸ 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 2: A case is sampled in January 2012. The State’s last action was a redetermination that occurred in December 2010. Since the last action occurred more than 12 months prior to the sample month of January 2012, eligibility is verified for January 2012 (the review month).

Example 3: A case is sampled in January 2013. The State’s last action was an annual redetermination which occurred on December 15, 2011 with an effective date of February 1, 2013. Although the last action occurred 13 months prior to the sample month of January 2013, the State would still review the case as of December 15, 2011 since the effective date of that redetermination was less than 12 months prior to the sample 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 it was 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 (except in the case of prospective eligibility) because case circumstances may have changed from the eligibility verification administered when the case was previously sampled.

80.1.2 Verification Standards

The purpose of the eligibility review is to verify the eligibility of sampled cases using State eligibility criteria in effect at the time of the decision under review. Resources that must be considered when reviewing cases for eligibility include:

- ▶ The State’s CMS-approved State Plan
- ▶ State regulations
- ▶ State eligibility manuals
- ▶ Eligibility worker procedural manuals
- ▶ Agency policy and procedural manuals and
- ▶ Other State documents or directives that reflect current policy

If the State plan or State policies are silent, reviewers should refer to the following Federal guidance:

- ▶ Federal laws and regulations
- ▶ The State Medicaid Manual
- ▶ State Health Official letters
- ▶ State Medicaid Director letters
- ▶ CMS Informational Bulletins
- ▶ Other written CMS guidance

The Eligibility Review Guidance determines the extent to which the review obtains evidence. CMS created these verification standards 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
- ▶ Documentation listed in section 7269 of the State Medicaid Manual

80.1.2.1 Required PERM Verification

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

80.1.2.2 Acceptable Documentation

The agency must examine the evidence in the case record and independently verify elements of eligibility where evidence is: (1) missing, (2) outdated and likely to change, or (3) otherwise as needed to verify eligibility. Outdated evidence is evidence that must be verified every 12 months and is older than 12 months prior to the sample month. Exhibit 10 lists examples of categorical and financial criteria that are likely and unlikely to change.

Depending on State policy and procedure, evidence in the case file could include:

- ▶ Eligibility worker notes, including documentation of client statement
- ▶ Written documentation of a face-to-face or phone interview
- ▶ Copies of documents provided from applicant or recipient
- ▶ Signed self-declaration statements.

Exhibit 10: Examples of Likely to Change and Unlikely to Change Categorical and Financial Eligibility Criteria

	Unlikely to Change	Likely to Change
Categorical Criteria	<ul style="list-style-type: none"> ▶ Citizenship (in month eligibility is being verified) ▶ Social Security Number ▶ Death ▶ Birth Date ▶ Pregnancy (in month eligibility is being verified) 	<ul style="list-style-type: none"> ▶ Residency ▶ Household Composition (for income relationship purposes)
Financial	<ul style="list-style-type: none"> ▶ Cash (resource⁹) ▶ House, other property (resource) 	<ul style="list-style-type: none"> ▶ Bank Account (resource) ▶ Earned Income – e.g., wages,

⁹ States must only verify resources for the PERM eligibility review if there is a requirement to verify resources during the original eligibility determination. This may include ensuring the eligibility worker inquired or investigated property ownership in accordance with State and Federal policy (e.g. Medicaid Long Term Care cases).

	Unlikely to Change	Likely to Change
Criteria	<ul style="list-style-type: none"> ▶ Vehicle ▶ Life Insurance (resource) ▶ Personal effects – e.g., boat, camper (resource) 	<ul style="list-style-type: none"> ▶ salary ▶ Unearned Income – e.g., RSDI, other government benefits, retirement income

Sufficient evidence of verification 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 2013, 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).
- ▶ Information from other agencies or databases or electronic records as long as it does not conflict with Medicaid or CHIP case record information.

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

80.1.2.3 *Acceptable Self-Declaration*

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

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.¹⁰

¹⁰ States should refer to Federal Medicaid and CHIP eligibility rules at 42 CFR Part 435 and Part 457 for citizenship verification and other Federal verification requirements.

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

- ▶ Present in the case record
- ▶ Not older than 12 months prior to the sample month
- ▶ Originating from the last case action that was not more than 12 months prior to the sample month
- ▶ In a State-approved, valid format, e.g., signed under penalty of perjury
- ▶ 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 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.

80.1.2.4 *Simplified Enrollment and Passive Renewal for Applications and Redeterminations*

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

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

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

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

- ▶ Self-declared information qualifies as acceptable self-declaration for PERM.
- ▶ Documentation that originates from the last case action is still acceptable verification for PERM even if more than 12 months old, particularly for applications with prospective eligibility and ex-parte determinations using data sources that are current at the time of the eligibility determination.
- ▶ If State policy is that when a beneficiary does not return their renewal form and the beneficiary is thus self-declaring and attesting that his/her circumstances are the same as the previous year, this self-declaration is considered current and acceptable for PERM when case record documentation is more than 12 months old. Keep in mind that if State policy and procedure was followed and led to an automatic renewal in accordance with State policy, nothing new must be re-verified for PERM. However if a beneficiary returns their renewal form to report changes, the eligibility worker must take appropriate action, or it could result in a PERM error.

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

80.2 Process for Verifying Active Case Eligibility

The process for verifying Medicaid and CHIP eligibility is outlined below. Note that because CHIP has the 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 re-determine eligibility. If the last action was taken more than 12 months before the sample month, verify eligibility as of the sample month. (Note: Exceptions are made for prospective eligibility and continuous eligibility.)

Step 2: Determine the State criteria for eligibility (i.e., categorical and financial criteria to be met for the coverage group under which the case is being reviewed).

Step 3: Examine the evidence in the case file that supports categorical and financial eligibility. Verify that information is:

- ▶ Missing
- ▶ More than 12 months old and likely to change
- ▶ Inconsistent with other facts
- ▶ Unacceptable under self-declaration guidelines

Step 4: For CHIP cases, verify whether the beneficiary was screened properly under the State's 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 80.1.2. 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:¹¹ An individual beneficiary or family is receiving benefits under the program but does not meet the State’s categorical and financial criteria using the State’s documented policy and procedures.

EI – Eligible with ineligible services: An individual beneficiary or family meets the State’s categorical and financial criteria for receipt of benefits under the Medicaid or CHIP program but was not eligible to receive particular services in accordance with the State’s documented policies and procedures.

U – Undetermined: The case record lacks or contains insufficient documentation, in accordance with the State’s documented policies and procedures, to make a definitive review decision for eligibility or ineligibility.

L/O-BP -Liability Understated- Beneficiary Premium: The caseworker incorrectly determined what the client’s premium amount should have been and the client was told to pay **less** for their premium amount than what the amount should have been; the state overpaid.

L/O-SD -Liability Understated – Spend Down: The caseworker incorrectly determined what the client’s spend down amount should have been and the client was assigned a spend down amount that was **less** than what the amount should have been; the state overpaid.

L/O-O - Liability Understated – Other: The caseworker incorrectly calculated an assigned liability amount or cost of institutional care (*other than a premium or spend down*)

¹¹ 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). For PERM, the case is considered “not eligible” for the purpose of calculating the case error rate.

and the client was assigned a liability that was **less** than the amount should have been; the state overpaid.

L/O- BP - Liability Overstated – Beneficiary Premium: The caseworker incorrectly determined what the client’s premium amount should have been and the client was told to pay **more** for their premium amount than what the amount should have been; the state underpaid.

L/O-SD - Liability Overstated – Spend Down: The caseworker incorrectly determined what the client’s spend down amount should have been and the client was assigned a spend down amount that was **more** than what the amount should have been; the state underpaid.

L/O –O - Liability Overstated – Other: The caseworker incorrectly calculated an assigned liability amount or cost of institutional care (*other than a premium or spend down*) and the client was assigned a liability that was **more** than the amount should have been; the state underpaid.

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.

TE-ACT – Technical error active universe – PERM review found an error in the case that did not affect eligibility or result in an improper payment

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

Step 8: Cases with findings of “Not Eligible” or with managed care errors or liability errors, should be forwarded to the State agency responsible for eligibility determinations so appropriate follow-up actions can be taken. When a case is found to be ineligible, the case should not be terminated from the program based on the PERM review findings. The correct action is to refer the case to the State agency for a redetermination.

80.3 Citing Undetermined Cases

If the agency cannot verify eligibility using the case record documentation or other independent sources, the following process must be followed prior to citing a case as Undetermined. The State should contact the beneficiary to obtain the needed information if information cannot be obtained from other sources. A missing case record does not automatically make a case Undetermined. The PERM reviewer must build a PERM review case record.

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
- ▶ Two contacts with reliable collateral sources (e.g., relative, authorized representative allowed to provide information concerning the beneficiary)

Although due diligence includes beneficiary contact, 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.

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.

Undetermined cases 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 as Undetermined.

Review all aspects of eligibility to ensure the accuracy of the entire determination. If one eligibility criterion cannot be verified, continue with the remainder of the review to ensure all other eligibility criteria can be verified.

80.4 Other Eligibility Review Situations

80.4.1 Presumptive Eligibility

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

- ▶ Pregnant women
- ▶ Women whose eligibility for Medicaid is based on needing treatment for breast or cervical cancer
- ▶ Children
- ▶ People with disabilities being discharged from the hospital into the community (section 6086 of the DRA that amends section 1915 of the Social Security Act)

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

For PERM, verify whether the case is within the presumptive eligibility period. If so, cite the case as Eligible. If the case is not within the presumptive eligibility period, verify that for Medicaid, an application was filed and the beneficiary is eligible for the program using the PERM review process in section 80.2.

80.4.2 100 Percent Federally Funded Cases

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

80.4.3 Continuous Eligibility

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

To review cases in continuous eligibility status for PERM, verify eligibility as of the date the State took the action to grant continuous eligibility based on an application or redetermination. PERM reviewers may not apply information from the current month to make an eligibility review decision. All verification must be based on the month of the last action.

80.4.4 CMS-Approved Waivers

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

- ▶ Natural disasters/States of Emergency
- ▶ Continuous Eligibility
- ▶ Delayed Redeterminations
- ▶ Presumptive Eligibility

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

80.4.5 SSI Conversion Cases

For SSI conversion cases, Federal regulations at 42 CFR §435.1003 limits Federal financial participation to the end of the month after SSA notifies the State of the loss of SSI (if received before the 10th of the month) or until the end of the next month (if notification is received after the 10th of the month) and requires a "prompt redetermination of eligibility." In 1634 States, Medicaid eligibility depends on the receipt of SSI cash. When SSI cash is lost then Medicaid eligibility no longer exists on this basis and the State must promptly re-determine eligibility to see if the person is eligible under another category.

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

80.4.6 Spend Down Cases

Spend down cases occur when a beneficiary's excess income must be offset with incurred medical expenses to gain eligibility. If a spend down case is sampled from the PERM active case universe, review the most recent action to grant eligibility or re-determine eligibility. Determine if the spend down amount was calculated correctly and determine if the expenses used toward spend down were appropriately allowed and calculated correctly.

80.5 Lost or Destroyed Eligibility Documentation

The PERM eligibility review involves the review of eligibility case records, including eligibility worker notes, hard copy case records and other sources, that provide information to review the eligibility status of selected cases. The Medicaid agency may be unable to obtain necessary documents due to loss from a natural disaster. In the event that an eligibility review cannot be completed due to such losses, the affected State will be allowed to drop the sampled case and replace it with an oversample case. More information for the policy for handling of lost or destroyed eligibility review records and documentation can be found on the PERM website at http://www.cms.gov/PERM/Downloads/lost_destroyed.pdf.

80.6 Eligibility Appeals

Although PERM requires the PERM eligibility review staff to be functionally and physically separate from personnel responsible for eligibility review policy and operations, CMS encourages transparency and coordination with the agency responsible for policy and operations in order to provide all applicable policies and procedural documents and guidance. 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 existing appeal process. States may also establish a new process for PERM eligibility appeals. More information on eligibility appeals can be found in the Eligibility Review Guidance in section 7 Agency Conducting Eligibility Reviews and Eligibility Appeals.

80.7 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

- ▶ 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 are required to document technical errors as appropriate and include analysis of technical errors and related corrective actions in their corrective action plans (CAP). Beginning with the FY 2013 cycle, States are required 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.

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

The negative case findings codes are as follows:

- ▶ **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.
- ▶ **TE-Technical error negative universe:** PERM review found an error in the case that did not affect the State’s decision to deny or terminate the case.

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 80.1.2.2, Acceptable Documentation or section 7269 of the SMM.

Step 3: 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 negative action can be supported, cite the case Improper Denial or Improper Termination.

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

Step 4: Determine if an improper denial or termination could be eligible for another category. Refer improper denial and termination case findings to the State agency responsible for eligibility determinations so appropriate action on an individual case can be taken. The State may evaluate the beneficiary's possible program reinstatement.

Step 5: The State may employ its eligibility appeals process (if applicable).

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

80.9 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. States are required to collect payments for services received in the sample month and paid in that month or the following four months plus any adjustments to the payments that occur within 60 days of the paid date. Do not apply any adjustments that occur after 60 days beyond the original paid date. 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 should not conduct a review of the actual payments (e.g. for medical necessity or coding). Rather, States should determine if the beneficiary's eligibility entitled them to the received services.

States must wait five months following the sample month before identifying claims. Claims are identified and associated with a case in accordance with the State's policy on effective date of eligibility. For example, most States provide "full month" coverage in that, if a beneficiary is eligible at any point during the month then the beneficiary's eligibility is effective as of the first day of the month. Other States have "date-specific" eligibility in that eligibility is effective on the date of the Medicaid application or, with CHIP, can be made effective prospectively. For States with date specific eligibility, collect payments for services received in the first 30 days of eligibility if eligibility is granted during the sample month. Cases with prospective eligibility must wait until the case is effective before collecting payments for services received.

Below we provide some examples to illustrate the timeframe for identifying a payment for a case sampled in October.

Example 1: A case sampled in October had a service received on October 15 which was billed by the provider in January and paid by the State on February 15. The claim was later adjusted by the State on April 1. The original payment would be counted in the payment review for the

sampled case because the service was received in October (the sample month) and paid in February which is within the five-month window for payment collection. The adjustment would also be considered because it was made on April 1 which is within 60 days of the paid date of February 15.

Example 2: A case sampled in October had a service received on October 15 which was billed by the provider in October and paid by the State on November 15. The claim was later adjusted by the State on December 15. The original payment would be counted in the payment review for the sampled case because the service was received in October (the sample month) and paid in November which is within the five-month window for payment collection. The adjustment would also be considered because it was made on December 15 which is within 60 days of the paid date of November 15.

Example 3: A case sampled in October had a service received on October 15 which was billed by the provider in October and paid by the State on November 15. The claim was later adjusted by the State on March 1. The original payment would be counted in the payment review for the sampled case because the service was received in October (the sample month) and paid in November which is within the five-month window for payment collection. However, the adjustment would not be considered because it was made on March 1 which is greater than 60 days after the paid date on November 15.

Example 4: A case sampled in October had a service received on October 15 which was billed by the provider in March and paid by the State on April 15. The claim was later adjusted by the State on June 1. The original payment and the adjustment would **not** be counted in the payment review for the sampled case because the service, though received in October (the sample month), was not paid within the five-month window for payment collection.

80.9.1 Instructions for Conducting Medicaid and CHIP Payment Reviews

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

Step 1: Identify services received in the sample month. States with date-specific eligibility should identify services received in the first 30 days of eligibility if eligibility was granted and effective in the sample month; or for date-specific eligibility, the first 30 days of eligibility.

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 that are paid in the sample month (or first 30 days of eligibility) and the subsequent four months, as applicable. The agency must also wait an additional 60 days after the original paid dates to apply adjustments. Also see section 6 Payment Reviews of Active Medicaid and CHIP Cases, in the PERM Eligibility Review Guidance for other payment review situations.

Step 3: Verify whether the payments were made appropriately based on the eligibility review findings. The payment review may include determining that 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 underpaid or overpaid 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. For example, 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, the total payments should be 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.

Any adjustments to claims that are the direct result of the eligibility reviews should not be included for the purpose of calculating the eligibility error rate.

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 11 below).

Exhibit 11: Five Month Payment Collection Falling Outside the Fiscal Year

FY 2012				FY 2013					
June	July	August	September	October	November	December	January	February	March
Services received									
Payments collected for services received in June									
			Adjustments for claims paid in June-October						
	Services received								
Payments collected for services received in July									
			Adjustments for claims paid in July-November						
	Services received								
Payments collected for services received in August									
				Adjustments for claims paid in August-December					
			Services received						
Payments collected for services received in September									
					Adjustments for claims paid in September-January				

80.10 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
- ▶ The detailed eligibility findings for active and negative cases
- ▶ The payment review findings on each sampled active case
- ▶ 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
 - The number and payment amounts for Undetermined cases

Please see the PERM Eligibility Review Guidance on the CMS PERM Website, 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.**

CMS will advise States of the format and methods for submitting eligibility data at the beginning of each cycle.

90 Difference Resolution and CMS Appeals Processes

There are potentially two levels of PERM error determination dispute that states may pursue, the difference resolution process and the CMS appeals process. These processes afford States the opportunity to overturn PERM error-determinations. The dispute processes collectively provide States with due process for disputing and overturning PERM error-determinations.

90.1 Difference Resolution Process

The difference resolution process is the first level of PERM error-determination dispute and provides the means by which States can dispute the Review Contractor (RC)'s medical review and data processing error findings. States that dispute PERM error-determinations through the dispute resolution process are eligible to appeal the difference resolution determination to CMS. States that do not pursue difference resolution are not permitted to appeal PERM error-determinations to CMS.

90.1.1 Notification of Difference Resolution Rights

The difference resolution process occurs after the review contractor publishes the PERM sampling unit disposition report of claims review findings on its website on the 15th and 30th of each month. States should review this report and a copy of the documentation submitted to the RC to determine whether they dispute the error-determinations cited in the report. Instructions for requesting difference resolution through the RC's website are located in the RC Website User Guide.

90.1.2 Eligibility for Difference Resolution

The following terms and conditions apply to the PERM difference resolution process:

- ▶ Only PERM-related medical review and data processing review errors are eligible for difference resolution
- ▶ PERM error-determinations that occur because records were not submitted to the RC (so-called "no documentation" errors) are not eligible for difference resolution
- ▶ A request for difference resolution must contain, at a minimum:
 - ❑ The factual basis for why a State disputes the RC's error-determination
 - ❑ Valid evidence directly related to the error determination to support a State's position that the claim in question (i.e., the error-determination) was properly paid

90.1.3 Difference Resolution Review Process

States must file a request for difference resolution through the RC's website within 20 business days of the date the State's PERM sampling unit disposition report was posted on the RC's website. The RC reviews the request for difference resolution and makes a determination—upholding, modifying, or overturning the initial PERM error determination. The RC has 15 days from the date it receives a request for difference resolution to issue its difference resolution determination. States are notified by email when the RC has posted the difference resolution decision to the RC website.

Error-determinations not challenged by a State are included in the error rate calculation. Error-determinations challenged by a State and upheld by the RC are included in the error

rate calculation unless a request for CMS appeal is filed by the State. Error-determinations overturned by the RC are not included in the error rate calculation.

90.2 State Appeal to CMS

The CMS appeal process is the second level of PERM error-determination dispute and provides the means by which a State can appeal the RC's difference resolution determination to CMS. A State may only appeal PERM error-determinations upheld by the RC.

90.2.1 Notification of CMS Appeal Rights

The RC posts the difference resolution determination to the RC's website and notifies States of the difference resolution determination by way of electronic notification (email). This notification also describes a State's appeal rights.

90.2.2 CMS Appeal Eligibility

The following terms and conditions apply to the CMS appeal process:

- ▶ A State must first dispute the PERM error determination through the PERM difference resolution process
- ▶ A State must file its request for CMS appeal through the RC website within 10 business days of receiving the difference resolution determination from the RC

90.2.3 CMS Appeal Process

Upon receiving a request for CMS appeal from a State, CMS will have access to the entire sampling unit record. The sampling unit record is a case file comprised of the following documents:

- ▶ A copy of the original PERM claim
- ▶ All medical records reviewed by the RC
- ▶ State policies pertaining to the claim
- ▶ Applicable screen shots (if data processing error being appealed)
- ▶ The RC's review notes
- ▶ A State's written arguments as presented during the difference resolution proceedings
- ▶ A State's written arguments as presented during the appeal request

CMS designates a review panel of PERM clinical and policy experts to conduct the appeal proceedings. The CMS review panel is limited to the review of the medical record that was reviewed before the PERM difference resolution contractor. CMS will post their decision on the RC's website within 45 days of receiving a State appeal and states will be notified through email when an appeal is completed. The decision of the CMS review panel is final and binding on a State that requests CMS appeal.

Error-determinations upheld by the CMS appeal review panel are included in the error rate calculation. Error-determinations that are overturned by the CMS appeal review panel are not included in the error rate calculation.

Note that if an error was found in both the data processing review and medical review for a specific claim, the total error amount reported cannot exceed the total paid amount for the claim.

90.2.4 Receipt of Additional Documentation

If a State pursuing CMS appeal submits documentation to CMS that was not submitted to the RC during initial review or difference resolution, the CMS appeal case is stopped and the administrative appeal process ends. CMS sends the new documentation to the RC for reconsideration.

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 is reviewed. 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 Cycle Cut-Off

Error rates will be calculated based on information received from states/providers by the cycle cut-off date. Typically, the cycle cut-off date is the second July 15 of a measurement cycle. However, the cycle manager may push back the cycle cut-off date depending on the progress of the cycle.

The RC will review documentation received by the cycle cut-off date and difference resolution/appeals requested by the cut-off date will be completed for error rate calculation.

Documentation received or difference resolution/appeals requested after the cycle cut-off date will not be included in error rate calculations. However, these instances may be eligible for continued processing.

100.2 Error Codes

See Exhibit 12 below for a summary of error codes for medical review, data processing review, and eligibility review.

Exhibit 12: PERM Error Codes

Medical Review Error Codes	Data Processing Review Error Codes	Eligibility Review Error Codes
<i>C 1 Correct</i>	<i>C 1 Correct</i>	<i>E Eligible</i>
<i>MR 1 No documentation</i>	<i>DP 1 Duplicate item</i>	<i>NE Not eligible</i>
<i>MR 2 Insufficient documentation</i>	<i>DP 2 Non-covered service</i>	<i>EI Eligible with ineligible services</i>
<i>MR 3 Procedure coding error</i>	<i>DP 3 FFS claim for a managed care service</i>	<i>U Undetermined L/O-SD Liability overstated – Spend down</i>
<i>MR 4 Diagnosis coding error</i>	<i>DP 4 Third-party liability</i>	<i>L/O-BP Liability overstated – Beneficiary premium</i>
<i>MR 5 Unbundling</i>	<i>DP 5 Pricing error</i>	<i>L/O-O Liability overstated - Other</i>
<i>MR 6 Number of unit(s) error</i>	<i>DP 6 Logic edit</i>	<i>L/U-SD Liability understated – Spend down</i>
<i>MR 7 Medically unnecessary service</i>	<i>DP 7 Data entry error</i>	<i>L/U-BP Liability understated – Beneficiary premium</i>
<i>MR 8 Policy violation</i>	<i>DP 8 Managed care rate cell error</i>	<i>L/U-O Liability Understated - Other</i>
<i>MR 9 Administrative/other medical review error</i>	<i>DP 9 Managed care payment error</i>	<i>MCE 1 Managed care error 1</i>
<i>MTD Medical review technical deficiency</i>	<i>DP 10 Administrative/other</i>	<i>MCE 2 Managed care error 2</i>
	<i>DTD Data processing technical deficiency</i>	<i>TE-ACT Active case technical error</i>
		<i>C – Correct (Negative case)</i>
		<i>ID – Incorrect denial (Negative case)</i>
		<i>IT – Incorrect termination (Negative case)</i>
		<i>TE – NEG Negative case technical error</i>

100.2.1 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 order of priority:

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 in both the nurse and coding tables. No difference resolution or appeal can be filed on these sampling units. A 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 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 14 days, the amount in error will be coded by the system as 100 percent of the amount paid for that sampling unit as an overpayment and the RC system will populate the findings as MR 2 in both the coding and nurse tables. 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 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 in both the nurse and coding tables. A 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 MR 8. Then the other (nurse or coder) screen will be coded as MR 8 by the system and the claim will be removed from the workload queue. 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 in both the nurse and coding tables. A re-pricing request 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 as MR 7. 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 in both the nurse and coding tables. 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.

100.2.2 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.

100.3 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.

100.4 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)

100.5 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 the PERM Eligibility Review Guidance on the CMS PERM Website. 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 3 error rates will be calculated for Medicaid and CHIP:

- ▶ A payment error rate, which is dollar weighted
- ▶ An active case error rate
- ▶ A negative case error rate

For information purposes, States will have the ability to calculate the State error rates two ways:

- ▶ Undetermined included as payment errors
- ▶ Undetermined excluded as payment errors

100.6 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
- ▶ CHIP Eligibility

Each component has its own universe and sample that are being measured. Because the payment components (i.e., 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,

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

and

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

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. The total number of strata is n .

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 n strata to obtain total dollars in error for the universe. Total payments are estimated in the same way, where $P_{i,j}$ is the total payments in the sample in stratum j for State i .

100.6.1 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 of possible bias if the sampled average payment amount differs from the universe average payment amount. 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. Second, 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_p represents total payments for FFS, managed care, or the total, depending upon the subscript.

100.6.2 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.

100.6.3 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 combination 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.¹² This is referred as the claims rate.

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

$$\begin{aligned}\hat{R}_{Medicaid} &= \frac{P_{MedicaidFFS} \hat{R}_{MedicaidFFS} + P_{MedicaidMC} \hat{R}_{MedicaidMC}}{P_{MedicaidFFS} + P_{MedicaidMC}} \\ &= S_{MedicaidFFS} \hat{R}_{MedicaidFFS} + S_{MedicaidMC} \hat{R}_{MedicaidMC}\end{aligned}\tag{1}$$

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)

100.6.4 Continued Processing

Continued processing occurs when a claim did not have time to go through the full PERM process before the cycle cut-off date.

Examples include:

- ▶ Medical records for a claim were received after the cycle cut-off date but within 75 days of the initial request for medical records
- ▶ An error was cited before the cycle cut-off date but the State’s allowable timeframe to request difference resolution and CMS appeal extended beyond the cut-off date

Claims will complete the PERM process through continued processing and CMS will recalculate a State’s error rate based on the continued processing results.

By PERM regulation, providers must submit medical documentation within 75 calendar days of the initial request from the Review Contractor or by the cycle cut-off date. Therefore, CMS will

¹² Cochran, W.G., Sampling Techniques. Third Edition. Wiley. 1977.

not accept any new documentation after the cycle cut-off date that is not part of continued processing. However, if a State has documentation to support that a claim previously called an error was correctly paid (e.g., successful provider appeal results, claim adjusted after PERM 60-day window) they can work with their CMS Regional Office financial contact to determine what adjustment to the expenditure reports is required for recovery purposes.

100.7 State-Specific Error Rate Recalculations

CMS will recalculate a State's error rate under two circumstances:

- ▶ A portion of the State's sampled claims underwent continued processing and errors were overturned/error amounts changed
- ▶ A mistake made by the PERM contractor was identified

CMS will issue recalculated error rates to all States affected by continued processing once continued processing is complete for a cycle. A new State-specific sample size for any affected component will also be calculated based on the recalculated error rate.

A state's error rate is factored into in the national rolling error rate for three years. Error rate recalculations will not be included in the first year error rate because the recalculations occur after this number is reported. However, State-specific error rate recalculations will be included in the next two years a State's error rate is included in the rolling rate.

National Error Rate Calculation

To go from the error rates for individual States to a national error rate, two steps are taken.

In the first step, 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 stratum h , and n_h is the number of States in the sample that is 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 second 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

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

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.

100.8 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. As an example, 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:¹³

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

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:¹⁴

$$\hat{Var}(\hat{R}_T) = c_1^2 \hat{\sigma}_{\hat{R}_1}^2 + c_2^2 \hat{\sigma}_{\hat{R}_2}^2 + c_3^2 \hat{\sigma}_{\hat{R}_3}^2$$

where:

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

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

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

¹³ See Hays, W.L., *Statistics for the Social Sciences*. Holt, Rinehart and Winston. 1973. Section 8.10.

¹⁴ Ibid.

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

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 Error Rate Targets

OMB guidance for implementing IPERA requires CMS to set targets for future erroneous payment levels for Medicaid and CHIP. Provided CMS has estimated a baseline error rate for the program, CMS is required to include a target for the program’s future erroneous payment rates in the AFR. Targets must be lower than the most recent estimated error rate.

110.1 National Error Rate Targets

CMS sets targets for the official three-year rolling national program error rate. Target error rates are set three years out from the most recently published error rate and are negotiated by OMB, HHS, and CMS. Current error rate targets can be found in the HHS AFR and on paymentaccuracy.gov.

CMS reported the first baseline three-year rolling Medicaid error rate in the 2010 AFR and is currently publishing error rate targets for Medicaid. Once a three year rolling rate baseline is established for CHIP, out-year targets will be set (the first CHIP baseline error rate is scheduled to be published in the 2014 AFR).

110.1.1 State-specific Error Rate Targets

The national Medicaid error rate is a compilation of State-specific error rates and, therefore, collaboration between CMS and the States is vital in achieving the national error rate target. CMS sets State-specific overall program and component error rate targets that allow CMS to collaborate with States to meet the national target.

When setting State-specific error rate targets, CMS asks States to reduce their component error rates by a fixed proportion relative to an “anchor” rate. The anchor rates are currently set at 1.5 percent for FFS, 1 percent for managed care, and 2 percent for eligibility. Each State must reduce the difference between the previous component error rate and the component anchor rate by 50 percent. States with component error rates in the previous measurement that are less than the anchor rates will be expected to achieve the same or better error rate in the next measurement period.

An example of how State-specific target error rates are calculated is shown below:

Exhibit 13: Calculation of State-specific target error rates

	FFS	Managed Care	Eligibility	Overall
<i>FY 2010 Rate</i>	3.6%	0.9%	3.6%	6.4%
<i>Anchor Rate</i>	1.5%	1%	2%	
<i>Difference between FY 2010 rate and anchor rate</i>	2.1%	N/A (under anchor)	1.6%	
<i>50 percent of the difference</i>	1.1%	N/A	0.8%	

	FFS	Managed Care	Eligibility	Overall
<i>Target FY 2013 Rate</i>	2.5%	0.9%	2.8%	4.9%

State-specific targets for a given PERM cycle are available when State error rates are released from the previous PERM cycle.

CMS may consider suggested adjustments to component targets, given the overall State target does not increase. There are currently no penalties or rewards in place if States do or do not meet their error rate targets.

120 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. States are required to submit a separate CAP for Medicaid and CHIP. 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. The specified due date is 90 calendar days after the date on which the State's error rates are posted on the RC's Website.

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. The new CAP should also include an evaluation of the previous submitted CAP. Through the CAP process, States are able to take administrative actions to reduce errors which cause improper Medicaid and CHIP payments.

The process of implementation of the CAP must start no later than 90 calendar days after the State's receipt of the Medicaid and CHIP error rates. Each CAP is in effect for three fiscal years and is updated after the next cycle's measurement and subsequent CAP submission.

120.1 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 CAP Team's primary responsibilities include working with the States to assist the States in the development, timely submission and implementation, and evaluation of previously submitted CAPs.

The CMS Region Office (RO) and the Medicaid Integrity Group (MIG) attend all calls scheduled by the Central Office PERM CAP team members (e.g., kick-off calls, State cycle summary call discussions, CAP evaluation, and other calls that are necessary and reasonable).

120.1.1 CAP Kick-off Call

In September, after the conclusion of the measurement review and prior to publishing the States' error rates on the website by the RC and in the AFR the PERM CAP Team will have an initial "CAP kick-off call" with all States in the measurement to discuss the corrective action process. Prior to the call several documents are forwarded to the State for review. These documents include a PowerPoint presentation explaining the CAP process, the October 2007 State Health Official (SHO) letter, a comprehensive CAP example, and a "kick-off call" agenda. The States are encouraged to invite whomever they feel needs to be included in this kick off conference call.

120.1.2 Individual State Calls

The next contact with the State is in November after the official error rate has been released and the contractor has posted the States error rate on the RC's website. Individual State specific calls

are made to the 17 States that were a part of the yearly measurement process to discuss the Cycle Summary Report which includes an Executive Summary and State-specific error analysis findings that are prepared by the contractors. The States are encouraged to invite whomever they feel needs to be included in this call.

120.1.3 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, States may decide whether a second call is needed for further discussion.

120.2 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 CAP progress to management and other stakeholders
- ▶ Developing strategies
- ▶ Making all major decisions on the planning, implementation and evaluation of corrective actions

120.3 Components of the Corrective Action Plan

CAPs are composed of five elements and required by regulation. The five elements are: data analysis, program analysis, corrective action planning, implementation and monitoring, and evaluation. States are required to submit a separate CAP for Medicaid and CHIP.

The CAP template and instructions are included in the appendix located on the PERM website.

120.3.1 Data Analysis

States must conduct data analysis such as reviewing clusters of errors, general error causes, characteristics, and frequency of errors that are associated with improper payments. Data analysis enables the state to gain a more thorough understanding of the root cause of the payment/eligibility errors, when the errors occurred, and who or what caused the error.

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 system edits, unreported changes in income that caused ineligibility)

The CAP should specify that data analysis actions are broken out by program area; i.e. fee-for-service errors, managed care errors, and eligibility errors. The CAP should specify that its data analysis is broke out by error classification (i.e. no documentation error, duplicate claim errors, ineligible due to excess income, etc.) The CAP should specify that its data analysis actions are structured to target identification of root causes of errors (e.g., providers not submitting medical records, lack of system edits, unreported changes in income that caused ineligibility.) The State should explain the overall mathematical approach utilized in conducting their data analysis. Note: States are not expected to convey in-depth mathematical analysis explaining how they conduct CAP-related data analysis activities.

120.3.2 Program Analysis

This component is the most critical part of the corrective action process where States must review the findings of the data analysis to determine the specific causes of the errors. States must identify the root causes of the errors to determine the best solutions (e.g., why providers are not complying with medical record 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.

Program analysis, along with data analysis, provides the framework for evaluating relevant information to determine the facts and causal factors in order to develop the most appropriate, timely corrective actions to resolve the finding and prevent recurrence. If errors look to have been caused by inadequate training, then the State should take actions to strengthen its training programs. This could be accomplished by worker interviews, questionnaires, policy reviews, and conferences with local managers, etc.

States must explain how its program analysis activities address 100 % of the payment and eligibility error-types. Although States may not be inclined to plan corrective actions for one-time error situations, such as human error, or corrective actions which are not cost-effective, States must nevertheless at least address the fact that this is its position.

States should describe how program analysis activities go beyond the surface cause (nature) of an error and looks to the root cause and describes actions that the State is taking to meet or exceed its PERM error-rate target, as specified by CMS. States should discuss why a particular program/operational procedure caused the specific error and identify the root causes of errors.

All errors should be addressed including deficiencies, eligibility-undetermined, active, and negative cases.

120.3.3 Corrective Action Planning

Based on the data and program analysis, States must determine what corrective actions are to be implemented. States must address each error type however it remains the States decision which corrective actions they take to decrease or eliminate errors. It may not be cost effective to implement corrective actions for each and every error; States must determine what corrective actions to implement. 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. A cost benefit analysis will aid the State in calculating the total expected cost of corrective actions against the benefits of corrective actions. If the State determines that the cost of implementing a corrective action outweighs the benefits then the final decision of implementing the corrective action is the State's decision. The cost benefit analysis and the final decision should be documented in the State's Corrective Action Plans submitted to CMS.

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.

States should explain their overall approach towards CAP planning, identify their PERM error-rate target goal, as specified by CMS, and explains actions that the state is taking to meet this target goal. States should describe the corrective action initiatives that the state will implement and how these actions will reduce or eliminate improper payments, including:

- ▶ Specific error causes being targeted
- ▶ Timeline—listing expected due-dates for resolving the problem(s) (causes of errors)
- ▶ Describes the plan to monitor implementation of the corrective action plan
- ▶ Specify the name and title of the person who has overall responsibility for the CAP

States are required to address all errors including deficiencies, eligibility-undetermined, active, and negative cases.

For cycles through FY 2012, States are encouraged to include corrective actions for eligibility technical errors in their CAP's. Beginning with the FY 2013 cycle, States are required to include corrective actions for eligibility technical errors.

120.3.4 Implementation and Monitoring

Develop an implementation schedule for each corrective action initiative whether it is Statewide or just in certain geographical areas. The implementation schedule must identify major tasks, key personnel or components responsible for each activity, and a timeline for each action including target implementation dates, milestones (e.g., start dates, final implementation dates), and the monitoring process. Federal regulations also specify that states must monitor their CAPs. The purpose of monitoring is to determine whether the implemented CAP is in the process of yielding intended results and meeting identified goals for reducing errors. Monitoring activities are ongoing, operational activities that the state undertakes while CAP activities are being implemented. Monitoring activities enable a state to keep track of its organization's ongoing efforts to reduce its PERM errors. An integral part of a successful corrective action program monitoring is maintaining a systematic approach for tracking and reporting the status of the corrective actions to successful closure and implementation.

States should develop an implementation schedule (timeline) for performing corrective action and describe the tasks necessary for CAP implementation and ties those tasks to the implementation schedule specifying milestones and implementation dates. States should describe their CAP evaluation activities and describe actions that the State takes to monitor implementation of its CAP.

120.3.5 Evaluation

Evaluate the effectiveness of the corrective action by assessing improvements in operations and/or error reduction. States may then decide to discontinue, modify, or terminate and replace the corrective action. States must evaluate the current corrective actions to be implemented by assessing all of the following:

- ▶ Improvements in operations
- ▶ Efficiencies
- ▶ Number of errors
- ▶ Improper payments

As part of its new CAP, States must evaluate and include updates on the previous corrective actions taken in their prior cycle including:

- ▶ Effectiveness of implemented corrective actions using reliable data; such as performing special studies, State audits, focus reviews, etc.
- ▶ When the action was implemented
- ▶ A status of the corrective action (is it complete, in progress, or ongoing?)
- ▶ Expected completion date and if the corrective action is on target
- ▶ Actions not implemented, and those actions, if any, that were substituted, ineffective, or abandoned actions and what actions were used as replacements
- ▶ Findings on short-term corrective actions
- ▶ The status of the long-term corrective actions
- ▶ States should determine if they meet PERM error-rate targets as identified by CMS

States should utilize the Medicaid FFS, managed care, and eligibility comparisons information in their cycle summary report to evaluate the effectiveness of the corrective actions taken in the previous cycle.

120.4 Corrective Action Plan Submission Details

CAPs are due to the assigned PERM State Liaison 90 calendar days after the date on which the State's error rates are posted on the RC's website. However, CMS encourages States to submit drafts to their designated PERM State Liaison 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. Final CAPs are submitted by the State to the appropriate PERM State Liaison for review and distribution to the appropriate CMS RO PERM contact staff and designated MIG staff. CMS will initially perform a high level review of the CAP to determine if each required element is addressed per regulation. If the CAP includes the required elements, the State will receive a letter of receipt acknowledging their CAP submission upon receipt of their CAP. If the CAP is not complete, States will receive a letter notifying them

of the missing element(s) and request to submit a revised CAP. When all elements are complete, the State will receive the acknowledgment letter. CAPs will then undergo a detailed review by CMS, Regional Offices, CMS's contractors, and Medicaid Integrity Group. CMS will provide collaborative comments to the State and the State may or may not be asked to submit a revised CAP based on feedback. After review of the CAPs by all parties, an individual call may be held for further discussion if there are additional questions or concerns.

The templates for the CAP Summary Form and the Detailed CAP can be found on the PERM Website under the Corrective Action Tab.

120.5 Post CAP Submission Activities

March 15 through end of April - After all CAPs have been evaluated, the PERM State Liaison, CMS RO PERM contact, and designated MIG staff, if needed, will participate in a conference call with each State to discuss the findings, request clarification, and determine if additional information should be requested from the State.

Webinars and Onsite – Each State is required to have a post-CAP webinar or onsite visit. This is an opportunity for active dialogue between the State, CMS, Regional Offices, Medicaid Integrity Group, and CMS' contractors. CMS presents information to the State on PERM initiatives and proposed improvements to the next PERM measurement. The State is required to do an oral presentation of their CAP.

CAP - Based on the meeting, States may need to submit revisions to their CAPs. States have 30 days from the meeting to submit revisions. States must notify their CAP liaison of any major changes to their corrective actions such as implementation, modifications, terminations, etc.

Follow-up – The CMS CAP liaison will contact States at least on a semi-annual basis to follow up on the State's CAP implementation between cycles.

130 Recoveries

CMS expects to recover the federal share on a claim-by-claim basis from the overpayments found in error. Within the PERM process, the only funds that can be recovered are from claims that were actually sampled and found to have contained improper payments resulting in overpayments.

Recoveries of overpayments are governed by longstanding statutory and regulatory requirements. The statutory and regulatory requirements for Medicaid are found under section 1903(d)(2) of the Social Security Act, 42 CFR Part 433 subpart F and for CHIP under section 2105(c)(6)(B) and 2105(e) of the Social Security Act, 42 CFR Part 457 subpart B and F.

According to 42 CFR 431.1002, States must return to CMS the federal share of identified overpayments based on the PERM data processing and medical reviews. Payments based on erroneous Medicaid eligibility determinations are addressed under section 1903(u) of the Social Security Act and related regulations at 42 CFR Part 431, subpart P.

For purposes of PERM, States are considered to be officially notified by CMS of identified improper payments by 1) the posting of Medicaid and CHIP Final Errors for Recovery Reports on the designated CMS RC's 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 have up to one year from the date of discovery of an overpayment for Medicaid and CHIP to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment. 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 is due on the next quarterly CMS-64 and CMS-21 in the Medicaid & CHIP Budget and Expenditure System (MBES/CBES). 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.

Exhibit 14: Version Control Updates

Date	Version	Description of Changes and Updates	Author
July 12, 2013	1.0	Added version control table, updated where appropriate to 2012 language, added DP, MRR, MR updates to August 30, 2012 CMS PERM Manual	A+ PERM Team (LCH, CM, MB, SK, AK)

October 15, 2013	1.1	Made updates to Introduction (Section 10) and Claims and Sampling (Section 20), Eligibility Universe and Sampling (Section 30), Eligibility Reviews (Section 80), Error Code Table (Section 100), incorporated CMS edits, updated where appropriate to 2014 language	Lewin (JM, AH)