

**DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS for MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop AR-18-50
Baltimore, Maryland 21244-1850**



Center for Program Integrity

**Medicaid Eligibility Quality Control (MEQC)
Sub-Regulatory Guidance**

November 15, 2018

Table of Contents:

Medicaid Eligibility Quality Control (MEQC) Program 3

- 1. Introduction..... 3
 - A. The MEQC and PERM Programs 3
 - B. MEQC Background 4
 - C. Procedures for Updates to this Guidance 4*
- 2. Definitions..... 5
 - A. Definitions under 42 CFR § 431.804 5
- 3. MEQC Program Operations..... 6
 - A. Required Activities and Timing 6

Table 1: MEQC Program activities by PERM cycle 7

- B. Federal Support for MEQC Activities 7
- C. MEQC Review Staff 7
- D. MEQC Planning Document 8
- E. MEQC Pre Review Activities 9

Table 2: Minimum* MEQC Sampling Requirements Under § 431.812 11

- F. MEQC Case Review Activities..... 12

Table 3: Eligibility Criteria (Elements): Considerations for Review..... 16

Table 4: Eligibility Processes: Considerations for Review..... 20

Table 5: Examples of Overstated/Understated Liability 24

- G. State Reporting..... 25

- 4. Access to Records Requirements 25

Appendix 1: Examples of MEQC Subjects for State Study..... 26

Appendix 2: Structure of State MEQC Planning Document 29

Appendix 3: MEQC Pilot Planning Cover Sheet..... 33

Appendix 4: Instructions for Completing MEQC Pilot Planning Cover Sheet..... 35

Appendix 5: List of Cycle 1, 2, and 3 PERM States..... 37

Medicaid Eligibility Quality Control (MEQC) Program

1. Introduction

The Medicaid Eligibility Quality Control (MEQC) Program provides states and the District of Columbia (hereinafter “states”) a unique opportunity to improve the quality and accuracy of their Medicaid eligibility determinations. It is intended to complement the Payment Error Rate Measurement (PERM) program and is focused on how states determine beneficiaries’ eligibility or ineligibility for services covered under Medicaid. The MEQC program is designed to reduce erroneous expenditures by reviewing eligibility determinations. It is likewise designed to ensure states operate to make accurate and timely eligibility determinations so that Medicaid and Children’s Health Insurance Program (CHIP) services are appropriately provided to eligible individuals.

The MEQC Program is distinct from, but works in conjunction with, the PERM program under 42 CFR 431 Subpart Q.

The MEQC Program is executed by states through “pilots” that allow states to evaluate the accuracy of their eligibility determinations, implement prospective improvements, and test the efficacy of corrective actions that are intended to address errors identified in Medicaid and CHIP eligibility determinations under the PERM program. The term “MEQC Pilot” refers to the process used by states to implement the MEQC Program. The MEQC pilots provide states with the necessary flexibility to target specific problems or high-interest areas as necessary. MEQC findings should prompt states to take action to mitigate their risks for improper payments during subsequent PERM review periods and improve the accuracy of their eligibility determinations.

A. The MEQC and PERM Programs

The MEQC and PERM Programs are distinct but complementary. This guidance document is focused on the MEQC program, and we make reference to the PERM program only as it interacts with the MEQC program. PERM program guidance is outside the scope of this document.

Under the PERM requirements at 42 CFR 431 Subpart Q, the PERM program annually measures the national Medicaid and CHIP improper payment rates and uses a 17-state three-year rotation process. The national Medicaid improper payment rate includes findings from the most recent three cycle measurements so that all states are captured in one rate. As such, each state is reviewed once every 3 years, and the year in which a state is measured is known as its “PERM year.” The state is not required to conduct a MEQC pilot during its PERM year. When a state is not under PERM review, i.e., in the 2 year interval between a state’s PERM review cycles, the state is required to conduct MEQC activities, including one (1) 12-month MEQC pilot. We refer to this 2 year interval between PERM review periods as PERM “off-years.” During the off-years,

the state's PERM eligibility improper payment rate is frozen. The MEQC Program provides states with the flexibility and opportunity to target eligibility areas of interest during the off-years. Targeting these areas of interest as well as specific issues found in previous PERM reviews can result in decreases in errors and deficiencies found in subsequent PERM Program eligibility reviews.

B. MEQC Background

On July 5, 2017, CMS published a final regulation entitled “Changes to the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) Programs (CMS-6068-F).” This final rule updated the MEQC and PERM programs based on the changes to Medicaid and CHIP eligibility requirements under the Patient Protection and Affordable Care Act (ACA). The MEQC program at 42 CFR §§ 431.810 through 431.822 was originally designed to implement sections 1902(a)(4) (“Administration Methods for Proper and Efficient Operation of the state Plan”) and 1903(u) (“Limitation of FFP for erroneous medical assistance expenditures”) of the Social Security Act (the Act). The earlier regulations established requirements for monitoring eligibility determinations and claims processing operations. Section 601(e) of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allowed states to substitute PERM data for MEQC in satisfying the requirements of Section 1903(u) of the Act.¹ The new regulations have formalized this by restructuring the MEQC program into an ongoing series of pilots that states are required to conduct during the two off-years between triennial PERM review years.

While states can use the MEQC pilots to address error prone areas identified during past PERM reviews and prepare for upcoming triennial PERM reviews, some additional MEQC requirements exist. One significant change is the requirement to conduct reviews of negative Medicaid and CHIP eligibility determinations as described section 3.F.2 below.

For additional background regarding the MEQC Program and its history, please refer to the July 5, 2017 final rule, “Changes to the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) Programs (CMS-6068-F)” at 82 FR 31158.

C. Procedures for Updates to this Guidance

This document will be updated and expanded. Please refer to the “Last Updated” information to see the date this document was most recently updated. When the document is updated, changes and edits will appear in red font for one update cycle.

¹ See 82 FR 31160, 31162.

2. Definitions²

A. Definitions under 42 CFR § 431.804

Active case means an individual determined to be currently authorized as eligible for Medicaid or CHIP by the state.

Corrective action means action(s) to be taken by the State to reduce major error causes, trends in errors or other vulnerabilities for the purpose of reducing improper payments in Medicaid and CHIP.

Deficiency means a finding in processing identified through active case review or negative case review that does not meet the definition of an eligibility error.

Deficiencies involve improper application of eligibility rules made in active or negative case determinations that do not have financial consequences. For example, if a state samples a case and finds it has erroneously placed a beneficiary in an incorrect Medicaid/CHIP eligibility category, but this mistake did not affect the beneficiary's ability to obtain medically necessary covered services or the federal or state share of Medicaid payments, it would be cited as a deficiency in state reporting on MEQC cases.

Eligibility means meeting the state's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs.

Eligibility error is an error resulting from the States' improper application of Federal rules and the State's documented policies and procedures that causes a beneficiary to be determined eligible when he or she is ineligible for Medicaid or CHIP, causes a beneficiary to be determined eligible for the incorrect type of assistance, causes applications for Medicaid or CHIP to be improperly denied by the State, or causes existing cases to be improperly terminated from Medicaid or CHIP by the State. An eligibility error may also be caused when a redetermination did not occur timely or a required element of the eligibility determination process (for example income) cannot be verified as being performed/completed by the state.

In contrast to deficiencies, eligibility errors made with reference to Medicaid or CHIP applications or redeterminations have financial consequences that result in actual or potential overpayments or underpayments. Generally, as described below (see section 3.F.VI.b), states will be expected to conduct "payment reviews" (reviews of claims from the case for a specified period of time) of errors found in eligibility determinations involving active cases in order to determine whether their Medicaid or CHIP Programs paid too much or too little federal financial participation (FFP) as a result of the errors (overstated or understated liability).

² The definitions in this section, with the exception of "Negative case errors," are taken from § 431.804 of the regulation. Italicized paragraphs in this section represent further clarifications and explanations that go beyond the language in the regulation.

Medicaid Eligibility Quality Control (MEQC) means a program designed to reduce erroneous expenditures by monitoring eligibility determinations and work in conjunction with the PERM program established in [42 CFR 431, Subpart Q].

MEQC pilot refers to the process used to implement the MEQC Program.

MEQC review period is the 12-month timespan from which the state will sample and review cases.

Negative case means an individual denied or terminated eligibility for Medicaid or CHIP by the state.

Negative case errors³ are errors, based on the State's documented policies and procedures, resulting from either of the following:

- (i) Applications for Medicaid or CHIP that are improperly denied by the State.
- (ii) Existing cases that are improperly terminated from Medicaid or CHIP by the State.

Off-years are the scheduled 2-year period of time between a states' designated PERM years.

Payment Error Rate Measurement (PERM) Program means the program set forth at [42 CFR 431, Subpart Q] utilized to calculate a national improper payment rate for Medicaid and CHIP.

PERM year is the scheduled and designated year for a state to participate in, and be measured by, the PERM Program set forth at [42 CFR 431, Subpart Q].

3. MEQC Program Operations

A. Required Activities and Timing

Each state is required to conduct an MEQC pilot in the 2 years between the state's PERM review periods. A pilot includes the following components:

- A state planning document that must be reviewed and approved by CMS
- Case reviews
- State reporting
 - A case-level report on the findings of these reviews, and
 - A corrective action plan (CAP)

Table 1 below reflects the timing of these required deliverables and activities.

³ As defined in 42 CFR 431.812(d)

Table 1: MEQC Program activities by PERM cycle

PERM Cycle*	PERM Review Period	MEQC: Planning Document Due to CMS	MEQC Review Period	MEQC: Case-Level Report on Findings and CAP Due to CMS
Cycle 1	July 1, 2017 - June 30, 2018	November 1, 2018	January 1 - December 1, 2019	August 1, 2020
Cycle 2	July 1, 2018- June 30, 2019	November 1, 2019	January 1 - December 1, 2020	August 1, 2021
Cycle 3	July 1, 2019 - June 30, 2020	November 1, 2020	January 1 - December 1, 2021	August 1, 2022

*see Appendix 5 for a list of states by PERM Cycle

B. Federal Support for MEQC Activities

States should claim federal funding for their MEQC pilot activities under the regular Medicaid administrative match or under the 10 percent administrative cap for CHIP, based on the workload of cases undertaken in each program. If questions about appropriate claiming arise, please address them to the Consortium for Medicaid & Children’s Health Operations in your CMS Regional Office.

C. MEQC Review Staff

I. Use of Contractors

States can utilize state staff (including existing MEQC/PERM review staff) or contractors to fulfill pilot requirements.

II. Reviewers: State Assurance of Independence

To ensure case reviews lack bias, 42 CFR 431.812(a) requires that the agency and personnel responsible for the development, direction, implementation, and evaluation of the MEQC reviews and associated activities must be functionally and physically separate from the state agencies and personnel that are responsible for Medicaid and CHIP policy and operations, including eligibility determinations.

As the integrity of an MEQC pilot depends upon MEQC reviewers’ independent and objective approach to the review process, CMS requires states to describe, in pilot planning documents, how reviewers will maintain independence. In addition to the narrative descriptions, we are requesting that states submit organization charts verifying the functional separation of staff and responsibilities.

D. MEQC Planning Document

Under § 431.812(a), MEQC pilot studies must be conducted in accordance with an approved pilot planning document.

Under § 431.814 states must submit an MEQC pilot planning document to CMS for approval by November 1 of the year following the end of the state's PERM year. As noted in Table 1 above, the planning documents for the PERM Cycle 1, 2, and 3 states will be due on Nov. 1, 2018, Nov. 1, 2019, and Nov. 1, 2020, respectively.

I. MEQC Planning Document: Form and Manner

The MEQC pilot planning document should be no longer than 20 pages.

The general instructions for what to include in the pilot planning document can be found at 42 CFR 431.814 and allow for further elaboration in subsequent CMS guidance. Accordingly, we are requesting that all pilot planning documents include an organization chart showing where state MEQC reviewers are housed and a discussion of how MEQC reviews are able to function independently of components that establish Medicaid eligibility policy and make eligibility determinations. We also require the pilot planning documents to include:

For active case reviews:

- A discussion of what, if any areas of focus in Medicaid and CHIP the reviews will have as well as a justification for any targeted areas.
- A description of the universe development process
- Information on the sample size per program (Medicaid and CHIP as well as any areas of focus)
- A discussion of the sample selection methodology
- A description of the case review process (see discussion in section 3.F. below), and
- A description of the payment review process to be undertaken for active cases in which errors are found

For negative case reviews:

- A description of the universe development process
- Information on the sample size per program (Medicaid and CHIP)
- A discussion of the sample selection methodology, and
- A description of the case review process (see discussion in section 3.F. below)

We have included in Appendix 2 a template for states to use in compiling their planning documents to help ensure that the necessary content is included. Appendix 3 contains a cover sheet which states must complete as an executive summary for their pilot proposals. Appendix 4 contains specific instructions for completing the cover sheet/executive summary.

States must submit their planning documents electronically to CMS's MEQC mailbox at CMS-MEQC-Inquiries@cms.hhs.gov. When submitting documents to the mailbox, please include the MEQC Coordinator's:

- Name
- Title
- Address
- E-mail
- Phone number(s)

II. MEQC Planning Document: CMS Review and Approval

The initial MEQC planning document must be submitted to CMS no later than November 1 of the same year in which the PERM review period ends on June 30.

CMS will communicate electronically with the designated MEQC coordinator.

Within 10 business days of receipt of MEQC planning documents from states, CMS will respond, to the designated MEQC coordinator with approval or with requests for additional information CMS needs to complete its review and approval.

In the event CMS requests additional information, the states will have 10 business days in which to respond to questions and amend their planning documents as needed.

Within 15 business days of receipt of additional information, unless there are unusual issues or concerns with a specific MEQC planning document requiring additional review, CMS will issue final approval of the planning document.

In addition, CMS will send a hard copy of a signed approval letter following the electronic transmission of the final approval of a state's MEQC planning document.

States must receive electronic notification of CMS' approval in order to begin an MEQC pilot study.

E. MEQC Pre Review Activities

As shown in Table 1 above, the MEQC review period runs from January 1 through December 31 of the year that follows the submission of the MEQC pilot planning document. This means that states may pull ~~claims~~ *samples* from January 1- December 31 of that year.

In the pilot studies, states will review a sample of active cases and negative case actions for errors and deficiencies in the case determination process and final results. Where eligibility determinations involving active cases are found to be in error, states will conduct a review of claims ("payment review") paid in the three months following the determination to assess the financial implications of the error. After the pilot studies end on December 31, states should report their results and develop a CAP for all errors and deficiencies identified. Note that the

three-month payment review period may spill over through March of the following year. A case level report on the pilot results and a CAP are due on August 1 of the following year.

I. Medicaid and CHIP Sample Universes

The sampling unit in the MEQC pilots is the individual eligibility determination, or “case.”

In establishing complete universes of Medicaid and CHIP cases from which to sample, states should identify, for each program, all active cases in the calendar year corresponding to their MEQC review period (see Table 1 above). If more than one approval or renewal occurred during the sampling timeframe, the most recent action that occurred should be included in the active case universe, not all of the activity that occurred during the sampling timeframe. States should subsequently exclude cases that are not eligible for MEQC review.

Regarding exclusions, *three* types of cases should be excluded from the Medicaid and CHIP universes:

- Express Lane Eligibility (ELE) cases: a separate analysis of ELE cases will be undertaken in states that have taken this option under Section 203 of CHIPRA 2009, Public Law 111-3.⁴
- Any cases that are supported by state-only funding.
- *Cases that are under ongoing fraud investigations.*⁵

In addition to establishing separate universes for active Medicaid and CHIP cases, states may choose to further stratify their sample universes to support the targeting of cases from specific areas of focus. To support stratified sampling, subgroups may also be established within the active case Medicaid universes, based upon, for example:

- Categories of eligibility, mandatory and optional
- Modified Adjusted Gross Income (MAGI),⁶ such as:
 - Adult expansion group
 - Parents/Caretaker Relatives
 - Pregnant women
 - Infants and children under age 21
- Non-MAGI-based, such as:
 - Supplemental Security Income (SSI) beneficiaries
 - Medically fragile populations
 - Nursing home residents

⁴ Express Lane Eligibility (ELE) is a CHIPRA option that allows states to enroll children into Medicaid or CHIP based on information available through other benefit programs and data bases.

⁵ *See the requirements for beneficiary and provider fraud investigations at 42 CFR 455 Subpart A.*

⁶ Modified Adjusted Gross Income (MAGI) is defined at 26 CFR 1.36 B-1(e)(2) and applied to certain Medicaid and CHIP eligibility determinations at 42 CFR 435.603(e).

- Beneficiaries in home and community based services programs

States have the option of reviewing an entire subgroup without sampling if this is feasible.

Stratified sampling within the CHIP universe is also permissible. For example, states that expanded coverage under title XXI through both a separate child health insurance program and through a Medicaid expansion program may wish to include cases from both programs. States may also wish to focus on pregnant women and/or children from conception to birth, to the extent a state provides coverage for those eligibility groups.

a. Sample Universe: Quality Control Procedures

In identifying the overall universe of case determinations and selected subgroups, we recommend that states perform quality control checks within the sampling time frames to ensure completeness and accuracy. Some examples of quality control checks include (but are not limited to):

- Selecting a preliminary test sample to ensure excluded cases have been removed from the universe
- Comparing the total count of pilot determinations in the overall universe (and total count of pilot determinations for each subgroup, if applicable) against existing benchmarks, such as official state enrollment reports, to assess reasonableness and completeness prior to sampling
- Reviewing total determinations (and subgroup totals, if applicable) in each month of the sampling timeframe to identify inconsistencies from month to month

II. Case Sampling

Regarding sampling requirements, under § 431.812(b) and 431.812(c) states must review a sample of at least 400 active and 400 negative cases. Within these totals, specific minimum numbers of Medicaid and CHIP cases must be sampled. The table below provides further detail. Note that states have the discretion to sample higher numbers of cases than the minimum thresholds specified in the regulation.

Table 2: Minimum* MEQC Sampling Requirements Under § 431.812

	Medicaid Program Sample	CHIP Sample	Total
Active Cases	200	At state’s discretion**	400
Negative Cases	200	200	400

*States may opt to review larger samples.

**States’ discretion to sample fewer CHIP active cases takes into consideration that a state’s CHIP sample universe may be smaller than its corresponding Medicaid Program sample

universe. Although there are no minimum sampling requirements for active CHIP cases, CMS strongly recommends that states include CHIP cases in their review of active cases. If a state chooses to sample no active CHIP cases, a justification for this must be provided in the planning document. Also note that state discretion regarding the number of CHIP active cases to sample does not alter the MEQC requirements for the total number of active cases that must be sampled. For example, if a state, based upon its sample universe sizes and MEQC Program goals, determines that its active CHIP case sample target is 100, the state must sample at least 300 active cases from the Medicaid universe to meet the required combined Medicaid-CHIP total of 400 active cases reviewed.

F. MEQC Case Review Activities

I. Active Case Reviews

For case reviews where an individual has been determined eligible for Medicaid or CHIP by the state, this section discusses active case review requirements and considerations.

a. Areas of Focus for Active Case Reviews

Under § 431.812(b)(3)(ii), if the eligibility component of a state's PERM improper payment rate is above the 3 percent national standard for two consecutive PERM cycles, CMS may require that state MEQC pilots include specific active case review components.

However, as long as a state's PERM error rate remains below the 3 percent national standard, the federal regulation at § 431.812(b)(3) provide states discretion to choose the eligibility groups or issues on which they want to focus for MEQC. The regulation describes that states may propose to focus active case reviews on:

- Recent changes to eligibility policies and processes
- Areas where the state suspects vulnerabilities
- Proven error-prone areas

Appendix 1 sets forth potential subject areas for MEQC reviews. CMS encourages states to use the MEQC process to pay close attention to, and focus substantial parts of their reviews on, eligibility groups and enrollment processes that have been subject to limited or no evaluation in the past.

For example, the determination of Medicaid eligibility based on MAGI is a relatively new process. Though it applies to only 33 states, the new adult group created by the Affordable Care Act accounts for approximately 13 percent of the national Medicaid population. Medicaid services to adults in this group were initially reimbursed at an enhanced FMAP of 100 percent and will gradually phase down to 90 percent in 2020. We recommend that all expansion states devote a portion of their MEQC Medicaid active case review to this group, at least in their initial pilots.

Ensuring that Medicaid-eligible beneficiaries have been placed correctly in the adult expansion group and have been claimed correctly may be of use to the state in several ways. It will not only prepare states for triennial PERM reviews, but it also can help reduce state exposure to overpayment findings in CMS financial management reviews and state auditor studies or HHS-OIG audits and evaluation reports.

Likewise, states should review verification procedures in areas where verification is required either by law (such as citizenship and immigration status or asset verification) or by the state's verification plan.⁷ In such cases, if the application process initially relies on self-attestation, a review might focus upon how such attestations were subsequently reviewed and verified, either by using information from trusted third party sources or, if unavailable from these sources, by using documentation provided by the applicant/beneficiary. For example, a review might include determining whether income reported or attested to by an applicant or beneficiary was reasonably compatible with the income listed in an electronic data source based upon the compatibility threshold identified in the state's verification plan.⁸ The case record should indicate what methods were used to verify citizenship or immigration status as required by law, as well as attestations regarding income, noting whether documentation confirmed (or did not confirm) the attestations, and when in the application process confirmation or non-confirmation was received.

For instance, states should be able to document that post-eligibility income verification occurred within 90 days of an eligibility determination.

Similarly, in presumptive eligibility (PE) cases, states should look to see if complete applications were submitted within the PE period, which generally ends on the last day of the month after a PE determination was made.

II. Negative Case Reviews

Negative case actions are determinations where eligibility for a new applicant is denied for Medicaid or CHIP or eligibility is terminated for a beneficiary in Medicaid or CHIP. While negative case reviews are not included in the PERM reviews, the review of negative case actions is a part of the new MEQC pilots. This section discusses negative case review requirements and considerations.

In a manner similar to what was said about active cases, states should establish complete universes of negative Medicaid and CHIP cases from which to sample by identifying all negative case actions for each program that occurred during the MEQC review period (see Table 1 above). If more than one negative case action for an individual occurred during the state's

⁷ 42 CFR 435.945(j) and 457.380(j), require states to develop, and update as modified, a Medicaid/CHIP verification plan describing the verification policies and procedures adopted by the agency in accordance with §435.940-435.965, and §457.380.

⁸ See 42 CFR 435.945(a)(i).

sampling timeframe, only the most recent denial or termination should be included in the negative universe.

a. Value and Baseline Requirements

An analysis of improper denials and terminations has considerable value from a continuous quality improvement standpoint. By studying erroneous negative actions, states will be able to identify staff training needs, faulty system interfaces, and other system errors that obstruct the eligibility determination process. In addressing these issues through ongoing corrective action, states may be able to reduce their appeals workload, litigation, and reputational risk.

In contrast to their review of active case determinations, states do not have leeway to focus on specific eligibility groups when reviewing negative case actions or on elements of the determination process that cut across multiple groups. States must instead sample a minimum of 200 Medicaid and 200 CHIP cases from the entire universe of negative Medicaid and CHIP cases, respectively, that are identified during the MEQC review period.

Although cases must be selected from the entire negative case universe, in conducting their reviews, states may want to pay special attention to whether certain types of negative case actions are prone to error or deficiency. These include:

- The inappropriate denial of or termination from Medicaid of children who were then placed in CHIP where they receive a greater share of federal funding but sometimes a less generous benefit package; and
- The denial of or termination from coverage for individuals who were not appropriately transferred or referred to a federally facilitated exchange (FFE) or a state-based marketplace (SBM)

The improper placement of Medicaid eligible children in CHIP continues to be an area of audit interest by oversight agencies, while both states and CMS still have much to learn about whether transfers from Medicaid/CHIP agencies to the exchanges are occurring seamlessly or not.

b. Other Considerations for Negative Case Reviews

More generally, states should review whether individuals were appropriately considered for all possible eligibility groups in MAGI Medicaid as well as non-MAGI before denials or terminations occurred. Reviewers should also pay close attention to whether timely issuance and filing of notices took place.

Particularly in states with separate MAGI and non-MAGI eligibility systems, states must check to see that individuals found ineligible for MAGI Medicaid are appropriately referred to the non-MAGI eligibility system, so that such individuals do not have to apply for Medicaid again to be evaluated for a non-MAGI eligibility group. Experience shows that this type of referral across systems has been problematic in states where newer MAGI-based eligibility systems must

interface with older legacy systems used in eligibility determinations for the non-MAGI populations.

In addition, states should classify errors they find in negative case determinations in a manner that will assist state personnel with developing effective CAPs. For example, states might consider the following classifications, among others:

- Denials or terminations based on the misapplication of eligibility-related criteria
- Denials or terminations based upon procedural reasons
- Human error versus system error

Lastly, in developing their studies of negative case actions, states may want to look for commonalities in denials and terminations that were overturned in the Medicaid fair hearing or CHIP review process and the reasons why such appeals were not upheld. A pattern analysis of this type may point states in the direction of issues or program areas worth studying as part of the negative case action review.

States will define the negative case actions as erroneous if, based on documented state policies and procedures, applications for Medicaid or CHIP are improperly denied, or existing Medicaid or CHIP cases are improperly terminated.

In general, most of the elements in Tables 3 and 4 below can be considered in reviewing negative case actions as well as active cases, although some may not apply and some will have different implications when considering Medicaid vs. CHIP or MAGI vs. non-MAGI cases.

III. Review Procedures

a. MEQC Case Review: Design

After the pilot planning document has been approved and sample selections are complete, the pilot review staff should begin conducting eligibility reviews designed to take into account state and federal policy to identify the accuracy of the eligibility determinations.

When considering how to design the review protocol, review staff should also consider internal and external processes that, while not resulting in eligibility determination errors, may result in deficiencies which need to be addressed through corrective actions.

The eligibility case review should focus on, for example:

- Whether a caseworker or eligibility system made the correct eligibility determination based upon information available at the time of the decision
- Whether an eligibility IT system's logic (as applicable) processes case information appropriately, including whether the system verifies information in data sources
- In situations where the eligibility system was overridden by the caseworker, whether the caseworker's actions were correct

- Whether electronic data sources were checked and utilized, where available, before paper documentation was requested

IV. Case-Level Reviews

Although states will review household composition and household income in order to assess whether an individual’s eligibility was correctly determined, states do not have to ascertain the eligibility of each member of the household.

For the person who is scrutinized, reviews should include all elements necessary to evaluate the correctness of overall program eligibility as well as the eligibility category.

The state’s case review should be a comprehensive review that includes all of the elements described below and any additional elements that the state uses to determine the appropriate program eligibility and eligibility group and a review of the eligibility determination process.

At a minimum, the eligibility criteria in Table 3 below should be considered when reviewing cases for the accuracy of eligibility determinations. States should also include information for any additional review elements that are not included in Table 3 below.

Table 3: Eligibility Criteria (Elements): Considerations for Review

Eligibility Criteria	Considerations
Income	<p>Was the state's reasonable compatibility standard, as specified in the verification plan, followed? Were income calculations correctly made based on MAGI vs. non-MAGI?</p> <p>Was the individual placed in the appropriate eligibility group based on income?</p>
Residency	<p>Was residency verified in accordance with state policies, including the state verification plan?</p>
Age (Date of Birth)	<p>Was age verified in accordance with state policies, including the state verification plan? Was the individual placed in the appropriate eligibility group based on age? Was the individual placed in managed care or a managed care plan based on age?</p>
Gender	<p>Was the individual placed in the appropriate eligibility group based on gender?</p>
Social Security Number	<p>Were state and federal policies followed in verifying the applicant's SSN?</p>

Eligibility Criteria	Considerations
Citizenship and Immigration Status	<p>Was citizenship/immigration status verified in accordance with state and federal policies?</p> <p>If applicable, did the state appropriately apply the reasonable opportunity period policy?</p>
Household Composition	<p>Was the household composition constructed properly? Was the income of all individuals appropriately included in or excluded from the household?</p>
Pregnancy Status	<p>Was the individual placed in the appropriate eligibility group based on pregnancy status?</p>
Caretaker Relative	<p>Was the individual placed in the appropriate eligibility group based on caretaker relative status?</p>
Medicare	<p>Was Medicare status determined appropriately? Was the individual placed in the appropriate eligibility group (e.g., Medicare Savings Program) based on Medicare status?</p>
Application for Other Benefits	<p>Was the individual eligible to apply for other benefits (such as Social Security, unemployment compensation, etc.)? If so, was the applicant referred to apply for those benefits?⁹</p>
Other Coverage (CHIP only)	<p>If the state has a waiting period, was the requirement met?</p>
Assets (For non-MAGI only)	<p>Were appropriate assets included/excluded from the state's calculation?</p> <p>Was the individual placed in the appropriate eligibility group based on assets?</p> <p>Were assets appropriately verified in the Asset Verification System (AVS)?</p>

⁹ See 42 CFR 435.608, Applications for other benefits.

(a) As a condition of eligibility, the agency must require applicants and beneficiaries to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so.

(b) Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.

Eligibility Criteria	Considerations
Transfer of Resources and Expenses (For non-MAGI only)	<p>Did the state ask for appropriate documentation related to resource transfers?</p> <p>Was the individual eligible based on resource transfer criteria?</p>
Medical Eligibility Requirements	<p>Did the state ask for appropriate medical eligibility documentation?</p> <p>Was the individual eligible based on medical eligibility requirements?</p>
Spend Down Expenses	<p>Did the state ask for appropriate documentation for expenses for the budget period elected by the state when calculating spend down for medically needy or 209(b) status?</p>
<p>Long-Term Care Specific Information (e.g., look back period assessment, spousal share, Miller Trust, etc.)</p>	<p>Did the state review 60 months of statements from all financial institutions found through the AVS or reported on the application as well as other resource information to determine countable assets and whether a penalty period should apply due to a transfer?</p> <p>If the applicant has a spouse, did the state gather the asset information for both individuals, and</p> <ul style="list-style-type: none"> • Look for transfers and • Determine the spousal share of assets allowable for the community spouse? <p>Did the state review any Miller trusts, special needs, or pooled trusts when determining eligibility to determine whether the transfer to the trust is allowable?</p> <p>Did the state properly calculate a personal needs allowance from the applicant/beneficiary's income?</p>
FFP	<p>Is the individual placed in the appropriate "FFP category"? Was the correct FFP claimed?</p>

For each of the eligibility criteria listed in the table above, states are required to provide the following information in the pilot planning document:

- Information regarding case-level data elements to be reviewed
- Information regarding data elements to be reviewed from the eligibility screen
- Information regarding how compliance with verification plan or AVS requirements will be reviewed
- Any additional criteria for eligibility review processes

Reviewers should also consider the process considerations in Table 4 below.

Table 4: Eligibility Processes: Considerations for Review

Process Findings	Considerations
Notices for Active and Negative Cases	<p>Were appropriate notices sent for both active and negative cases that included all required and accurate information? Were notices sent in a timely manner?</p>
Denial and Termination Transfers	<p>Were children, and pregnant women if applicable, denied or terminated from Medicaid evaluated for CHIP if applicable?</p> <p>For states utilizing FFE:</p> <ul style="list-style-type: none"> • Were denied or terminated cases transferred to the FFE appropriately for a qualified health plan determination? <p>For states utilizing SBM:</p> <ul style="list-style-type: none"> • For SBM states that do not have shared eligibility system, was denied/terminated case sent to SBM appropriately for qualified health plan determination? <p>Were individuals aging out of the adult group appropriately evaluated for Medicare Savings Programs or other Medicaid eligibility categories?</p>
Transfers from FFE/SBM	<p>If the application was transferred from the FFE or SBM, was information reused appropriately in accordance with verification plan?</p>
Caseworker action	<p>If both system edits and caseworker actions were part of the eligibility determination process, did the caseworker override the system's business rules correctly? Was the override appropriate?</p> <p>For system actions where information was received manually from an outside entity, was the information entered into the system appropriately and timely?</p>
Applicant Information Requests	<p>When obtaining verifications, did the system/caseworker attempt to locate electronic third party data sources as required by the regulations for citizenship and immigration status and did the caseworker adhere to the state's verification plan and/or query the AVS before requesting paper verifications from the applicant or beneficiary?</p>
Timeliness	<p>Was case processed within the required state and federal timeframe? Was renewal conducted in last 12 months?</p>

States should be clear in the planning document that the criteria review information submitted will thoroughly address all aspects of the eligibility determination process. States can provide lists of general information that will be reviewed for each eligibility criterion (element). States should not provide a detailed list of every possible source of information.

Please note that all elements may have different implications for Medicaid vs. CHIP or MAGI vs. non-MAGI cases. Similarly, not all required review elements apply to both active and negative cases or to both initial determinations and redeterminations.

In general, reviewers will evaluate each case for all required eligibility criteria to confirm that the state made the appropriate determination of eligibility, given the information available on the application, from trusted third party data sources, and via hard copy documentation, as applicable. This includes the following:

a. Review against Federal and State Guidance and Policies

In making determinations, states should use the following sources of policy as a frame of reference:

- CMS-approved State Plan
- State and federal regulations
- State policy and procedure manuals
- MAGI-Based eligibility verification plan and amendments
- Approved waivers and mitigation plans
- Federal guidance
- Memoranda
- Application forms and other standardized forms

b. Review of Calculations

For system actions where calculations (e.g., income, household composition) were conducted as part of the determination, the reviewer should independently review the information used by the system and determine if calculations were done correctly. The reviewer should manually calculate income and household composition to evaluate whether the calculation performed by a caseworker or system was correct.

c. Review of Third Party Data

For systems actions where data or information used to determine eligibility is received from an external source, the review should include making a determination regarding whether the external information entered the system or factored in the determination appropriately and timely.

Regarding third party data used to verify self-attested information that was included on the application, the review should include determining whether system actions or interactions

appropriately considered the data in accordance with the state's verification plan and other state and federal policies.

d. Review of Paper Verifications

When determining eligibility, the eligibility system or caseworker should solicit and rely upon available third party data prior to requesting paper documentation from a prospective beneficiary. If the caseworker did not follow the state's verification plan, for example by requesting paper verifications without attempting to obtain verifications electronically, this action will be identified as a deficiency.

e. Review of Eligibility Category for Active Cases

Upon finding an active case was determined correctly, the reviewer should further determine whether an individual was placed into the correct eligibility category.

f. Review of Subsequent Action for Negative Cases

Upon finding a negative case was determined correctly, the reviewer should further determine whether the individual was appropriately transferred to the SBM or FFE.

g. Review of Manual Override Cases

In situations when a caseworker overrides system logic to enter information manually, the reviewer should determine whether the caseworker's actions occurred timely and appropriately. The state should likewise report, as a finding, when a caseworker override should have occurred but did not occur.

h. Review for Timely Action

The reviewer should determine whether an eligibility determination was made within the allowable timeframes {see 42 CFR 435.912(c)(3) for Medicaid and 42 CFR 457.340(d) for CHIP}.

V. Communication with Beneficiaries or Individuals Denied for Coverage

States should not contact beneficiaries as part of their MEQC pilot reviews. Rather, reviewers should rely on the evidence available in case records when deciding whether eligibility determinations or negative case actions involved errors or deficiencies or whether, based on the available documentation, it could not be determined if a case was adjudicated correctly.

That said, after the state's MEQC pilot is complete, *state* personnel may follow up with beneficiaries while undertaking corrective actions and root cause analyses in certain situations.

VI. MEQC Findings: Payment Review

Where eligibility determinations involving active cases are found to be in error, states will conduct a review of claims paid in the three (3) months following the determination to assess the financial implications of the error.

a. Approved Medicaid Management Information System (MMIS)

Under § 431.806(d), states must have an approved Medicaid Management Information System (MMIS) under 42 CFR 433 Subpart C in order to undertake the payment review piece of their pilot studies. If a state does not have a certified MMIS, it must otherwise have a Medicaid quality control claims processing assessment system that meets the requirements of § 431.830 through § 431.836.

b. Payment Review Process:

States are required to undertake a payment review of those sampled active cases in which errors resulted in a likely overpayment or underpayment. In general, the payment review period should cover claims submitted in the first three (3) months after the erroneous eligibility determination occurred. CMS recognizes that there may be policy and practical reasons why some states may prefer a different payment review period. States which seek to use a different period should explain the rationale for this in the pilot planning document.

Where eligibility determination errors have resulted in probable overpayments, the state should total the number of claims that Medicaid paid in error over the stipulated payment review period, list the total overpayment and provide the estimated amount of FFP that was overpaid. Where a beneficiary was determined eligible but placed in the wrong eligibility group, different types of calculations may have to take place. For example, in the case of beneficiaries placed in the adult expansion group as new eligibles who should have been in a different eligibility group (or in the adult group but not as newly eligible), the state would be expected to calculate the amount of extra FFP paid on Medicaid covered services that the beneficiary received.

It is possible that states will identify errors that involve underpayments. It may not always be possible to identify the sum of these. For example, there is no way to calculate the full amount of Medicaid payments that might have been issued on behalf of a beneficiary enrolled in a MAGI-eligible Medicaid category who should have been eligible for long term care services. The same might be true of a beneficiary placed in a traditional family category who should also have been eligible for tuberculosis-related services. On the other hand, some underpayments can be calculated. For example, this should be possible for beneficiaries placed in a traditional MAGI-based Medicaid category who should have been in the adult expansion group.

The table below provides examples of overstated and understated liability with respect to FFP and benefits. When liability is overstated, too much FFP is claimed or too many benefits are conferred. When liability is understated, the converse is true: too little FFP is claimed or too few benefits are conferred.

Table 5: Examples of Overstated/Understated Liability

	Overstated Liability	Understated Liability
FFP Impact	<ul style="list-style-type: none"> • Found eligible in Adult group, as a newly eligible but should have been either not newly eligible or eligible in the parent/caretaker relative group • Found eligible as a child in CHIP, should have been eligible in the Medicaid children's group • Found eligible in Adult group, as a newly eligible but should have been eligible in the former foster care group • Found eligible for Adult group, should have been eligible in the Pregnant women group 	<ul style="list-style-type: none"> • Found eligible for family planning, should have been found eligible for Parent/Caretaker relative group • Found eligible for the Medicaid children's group, should have been eligible for CHIP • Found eligible for CHIP, should have been found eligible as a newly eligible in the Parent/Caretaker relative group
Benefits Impact	<ul style="list-style-type: none"> • Found eligible for the children's group, should have been eligible in the Parent/Caretaker relative group • Found in the former foster care group, should have been eligible for family planning • Found eligible for the Aged, Blind and Disabled (ABD) group, should have been eligible as a Specified Medicaid Low Income Beneficiary (SLMB)¹⁰ 	<ul style="list-style-type: none"> • Found eligible for Pregnant women group, should have been eligible in the children's group • Found eligible for emergency Medicaid, should have been eligible in the Pregnant women group • Found eligible for medically needy spend down, should have been eligible in the ABD group

c. Payment Adjustments

After completing an MEQC pilot study and submitting it for CMS review, each state will be expected to tally the overpayments and underpayments that can be calculated from active case errors and report over- or underpayments on the appropriate line on the CMS-64 quarterly reports for Medicaid and the CMS-21 quarterly reports for CHIP within the Medicaid Budget and Expenditure System.

¹⁰ As defined at 1902(a)(10)(e)(iii) and 1905(p)(3)(A)(ii) of the Social Security Act.

G. State Reporting

Under 42 CFR § 431.816 and § 431.820, states must submit case level reports on their MEQC pilot studies and CAPs which address any active or negative case errors, including deficiencies and their root causes.

I. Case Review Reports

We will provide information about the requirement for case-level reports in a subsequent release of sub-regulatory guidance.

II. Corrective Action Plans

We will provide information about the requirement for CAPs in a subsequent release of sub-regulatory guidance.

4. Access to Records Requirements

This guidance will be updated to provide information regarding the access to records requirements at 42 CFR 431.818.

Appendix 1: Examples of MEQC Subjects for State Study

Subject	Medicaid MAGI	Medicaid Non-MAGI	CHIP
<p>Adult Group Enrollment In expansion states, review for appropriateness of enrollment in adult group and accuracy of FMAP claiming (only claiming enhanced FMAP for newly eligible individuals)</p>	X		
<p>Income Counting and Household Composition Rules for both MAGI and non-MAGI Review a mix of cases for appropriate application of household composition and income counting rules</p>	X	X	X
<p>MAGI – Household composition</p> <ul style="list-style-type: none"> • Three-generation households • Family size for a pregnant woman in the HH, depending on state option • Non-<i>Title</i> IV-E foster care children living with no birth siblings and living in a sibling group • Applying tax filer rules • Child/tax dependent exceptions? 	X		
<p>MAGI –Income counting</p> <ul style="list-style-type: none"> • Counting of Social Security benefits for children/tax dependents • Reasonably predictable changes in future income • Self-employment/business income with a loss or a carry forward of a prior year loss • Counting of VISTA income 	X		
<p>Renewal Assess timeliness of redetermination and the appropriate use of data sources to attempt to conduct a renewal before requesting additional information from a beneficiary</p> <ul style="list-style-type: none"> • States that implemented an e14 waiver¹¹ at renewal • Ex parte renewals • Appropriate application of continuous eligibility 	X	X	X
<p>Immigrant Eligibility</p>	X	X	X

¹¹ This refers to a waiver of the provisions of 1902(e)(14) of the Social Security Act (as created by the Affordable Care Act) that requires states to apply MAGI for income eligibility and other income-dependent determinations (e.g., premium assessment). The Secretary of the U.S. Department of Health & Human Services has the authority to temporarily waive these requirements in Medicaid and CHIP under certain circumstances “to ensure that States establish income and eligibility determination systems that protect beneficiaries.”

Subject	Medicaid MAGI	Medicaid Non-MAGI	CHIP
Review accuracy of assessment of immigrant eligibility and appropriate verification <ul style="list-style-type: none"> • Five year bar • Mixed immigration-status households • Counting of sponsor deeming income 			
<i>Verification Documentation</i> Review a mix of cases to ensure sufficient documentation appears in the case file to confirm eligibility	X	X	X
<i>Systems issues</i> Review to determine whether the cascade is working correctly <ul style="list-style-type: none"> • Placement of adults in TMA; placement of children in TMA at the appropriate time • Placement of former foster care youth in the appropriate group in the hierarchy • Enrollment of gap-filling cases correctly in Medicaid • Placement of CHIP-funded children in Medicaid expansion as opposed to a separate CHIP 	X	X	X
<i>Enrolling and maintaining coverage for vulnerable populations</i> <ul style="list-style-type: none"> • Individuals aging out of foster care- whether transitioned to former foster group • Homeless youth • Non-Title IV-E adoption assistance within a state and moving interstate • Incarcerated individuals or individuals re-entering into the community 	X	X	X (for in-carcerated)
<i>Family planning group</i> Review eligibility determinations to determine: <ul style="list-style-type: none"> • Are MAGI-based methods used for the group? • Is household income calculated correctly where the state elects to vary household size or income counted for the group? • Is family planning group in the correct placement in the eligibility hierarchy? 	X		
<i>Institutional eligibility</i> Review a mix of active and negative cases, active cases for appropriate calculation of income and assets and appropriate verification, negative cases for correct denial or termination and appropriate notice		X	

Subject	Medicaid MAGI	Medicaid Non-MAGI	CHIP
<ul style="list-style-type: none"> Where the institutionalized person has a spouse and or children living outside of the institution in the home 			
<p><i>Institutional eligibility</i> Review a mix of active cases to determine if the Post Eligibility Treatment of Income (PETI) was calculated correctly and there was a proper deduction of incurred medical expenses</p>		X	
<p><i>Institutional eligibility</i> Review a mix of active and negative cases to determine if the penalties for transfers of assets (annuities, spousal trusts) were calculated correctly</p>		X	
<p><i>Spend down</i> Applicants who meet all eligibility requirement except for income. Eligibility occurs when the allowable medical expenses exceed the states income threshold</p>	(MAGI-like)X	X	

Appendix 2: Structure of State MEQC Planning Document

States must use the following template in organizing their MEQC Planning Documents

- **Page limit:** Maximum 20 pages in length not counting cover sheet;
- **Due Date:** Due Nov. 1 in year each PERM review period ends):

- **Cover sheet**
 - Include a cover sheet with quantitative summary of the pilot planning document. A model cover sheet and instructions for completing it are included as Appendix 3 and 4, respectively.

- **Section 1: Introduction**
 - **Summary Statement:** Include appropriate summary statement of state's goals in undertaking this pilot, if needed.
 - **Organization Chart:** Include appropriate organization chart(s) as well as a narrative explanation in order to document how the staff undertaking and overseeing the MEQC review are functionally separate from and independent of staff responsible for establishing eligibility policy and undertaking eligibility determinations.
 - **Point of Contact:** Include name, title, address, phone number and e-mail address of a designated MEQC Coordinator.

- **Section 2: Active Cases--Medicaid**
 - **Entire universe or stratification.** Indicate whether state intends to do a sampling of the entire Medicaid universe of active cases or study different areas of focus in the Medicaid population.
 - **Entire Universe Justification.** If sampling the entire Medicaid universe of active cases, provide justification for this approach and discuss how the universe will be developed.
 - **Active Case Sampling Plan.** Indicate the total universe of active Medicaid cases, confirm time frame over which universe will be calculated, and indicate total Medicaid sample to be selected.
 - **Certification of active case sample size:** Certify that the minimum regulatory requirement of sampling at least 400 active cases will be met, of which at least 200 are Medicaid.
 - **Sampling method:** Explain the method to be used in selecting the sample of active cases from the entire Medicaid universe. This includes a description of the frequency with which the sample of active Medicaid cases will be pulled (monthly, quarterly, etc.).

- **Case Review Plan/Quality Control:** If you sampled the entire Medicaid universe of active cases, describe the methodology that will be used to assess whether the selected cases were appropriately determined or if errors or deficiencies were made.

If you did not sample the entire Medicaid universe of active cases proceed below to the section on “Areas of Focus—Medicaid.”

- **Section 3: Active Cases --CHIP**

- **Entire Universe or Stratification.** Indicate whether state intends to do a sampling of the entire CHIP universe of active cases or study different areas of focus in the CHIP population.
 - **Entire Universe Justification.** If sampling the entire CHIP universe of active cases, provide justification for this approach and discuss how the universe will be developed.
- **Active Case Sampling Plan.** Indicate the total universe of active CHIP cases, confirm time frame over which universe will be calculated, and indicate total CHIP sample of active cases to be selected. **Provide justification if the state has chosen to sample no active CHIP cases.**
- **Sampling method:** Explain the method to be used in selecting the sample of active cases from the entire CHIP universe. This includes a description of the frequency with which the sample of active Medicaid cases will be pulled (monthly, quarterly, etc.).
- **Case Review Plan/Quality Control:** If you sampled the entire CHIP universe of active cases, describe the methodology that will be used to assess whether the selected cases were appropriately determined or if errors or deficiencies were made.

If you did not sample the entire CHIP universe of active cases proceed below to the section on “Areas of Focus—CHIP.”

- **Section 4: Areas of Focus—Medicaid (if applicable)**

- Medicaid Active Cases
 - **Description:** Describe each area of focus to be studied for active Medicaid cases.
 - **Justification:** Provide a short justification for each active case Medicaid area of focus.
 - **Sampling plan.** Describe total universe, sampling time frame, and total sample to be selected for each Medicaid active case area of focus.

- **Sampling Method:** Describe the sampling method to be used in selecting the sample of Medicaid active cases for each area of focus to be studied (pure random sampling, oversampling for certain kinds of cases, etc.).
 - **Frequency of sampling:** Describe the frequency with which the sample of active Medicaid cases will be pulled (monthly, quarterly, etc.).
 - **Case Review Plan/Quality Control:** For each active case area of focus chosen, provide a concise description of the methodology that will be used to assess whether the selected cases were appropriately determined or if errors or deficiencies were made.
- **Section 5: Areas of Focus—CHIP (if applicable)**
 - **CHIP Active Cases**
 - **Description:** Describe each area of focus to be studied for active CHIP cases.
 - **Justification:** Provide a short justification for each active case CHIP area of focus.
 - Describe total universe, sampling time frame, and total sample to be selected for each CHIP active case area of focus.
 - **Sampling Method:** Describe the sampling method to be used in selecting the sample of CHIP active cases for each area of focus to be studied (pure random sampling, oversampling for certain kinds of cases, etc.).
 - **Case review plan:** For each CHIP active case area of focus chosen, provide a concise description of the methodology that will be used to assess whether the selected cases were appropriately determined or if errors or deficiencies were made.
- **Section 6: Negative Case Actions—Medicaid**
 - **Negative Case Sampling Plan.** Indicate the total universe of negative Medicaid cases, discuss how the universe will be developed, confirm time frame over which universe will be calculated, and indicate total Medicaid sample of negative case actions to be selected.
 - **Certification of active case sample size:** Certify that the minimum regulatory requirement of sampling at least 400 negative cases will be met, of which at least 200 are Medicaid.
 - **Sampling method:** Explain the method to be used in selecting the sample of negative case actions from the entire Medicaid universe.
 - **Frequency of sampling:** Describe the frequency with which the sample of negative Medicaid case actions will be pulled (monthly, quarterly, etc.).

- Case Review Plan/Quality Control: Describe the methodology that will be used to assess whether the selected negative Medicaid case actions were appropriately determined or if errors or deficiencies were made.
- **Section 7: Negative Case Actions—CHIP**
 - Negative Case Sampling Plan. Indicate the total universe of negative CHIP cases, discuss how the universe will be developed, confirm time frame over which universe will be calculated, and indicate total CHIP sample of negative case actions to be selected.
 - Certification of active case sample size: Certify that the minimum regulatory requirement of sampling at least 400 negative cases will be met, of which at least 200 are CHIP.
 - Sampling method: Explain the method to be used in selecting the sample of negative case actions from the entire CHIP universe.
 - Frequency of sampling: Describe the frequency with which the sample of negative CHIP case actions will be pulled (monthly, quarterly, etc.).
 - Case Review Plan/Quality Control: Describe the methodology that will be used to assess whether the selected negative CHIP case actions were appropriately determined or if errors or deficiencies were made.
- **Section 8: Payment Review Process (Active Cases Only)**
 - Description: Describe the process the state will use to identify overpayments or underpayments in all **active** Medicaid and CHIP cases where erroneous eligibility determinations were found.
 - Timeframe: Describe the timeframe over which the payment review process will be conducted. Provide a justification if the timeframe is different from the specifications provided in this document.
 - Deficiencies: Describe how the state will confirm that no incorrect payments were in fact made for **active** cases in which deficiencies were identified.
- Conclusion or Summary Statement (Optional)

Appendix 3: MEQC Pilot Planning Cover Sheet

MEQC Pilot Planning document Cover Sheet				
Name of State & Date Submitted				
Contact Person				
Phone				
E-Mail				
MEQC Review Period	Jan. 1 – Dec. 31, 20__			
Active Cases (minimum of 400 & at least 200 Medicaid required)				
Universe Size (Indicate Medicaid, CHIP, and Grand Total)				
Time Frame of Universe				
Total Sample selected (Indicate Medicaid, CHIP, and Grand Total)				
Active Case Areas of Focus—Medicaid				
Indicate NO here if you have no Medicaid active case areas of focus & skip this section				
Description Area of Focus 1	Description Area of Focus 2	Description Area of Focus 3	Description Area of Focus 4	Description Area of Focus 5
Universe 1	Universe 2	Universe 3	Universe 4	Universe 5
Sample Size 1	Sample Size 2	Sample Size 3	Sample Size 4	Sample Size 5
Active Case Areas of Focus—CHIP				
Indicate NO here if you have no CHIP active case areas of focus & skip this section				
Description Area of Focus 1	Description Area of Focus 2	Description Area of Focus 3	Description Area of Focus 4	Description Area of Focus 5
Universe 1	Universe 2	Universe 3	Universe 4	Universe 5
Sample Size 1	Sample Size 2	Sample Size 3	Sample Size 4	Sample Size 5

Negative Cases (minimum of 400 required [200 Medicaid, 200 CHIP])	
Universe Size of Medicaid Negative Case Actions	
Time Frame of Negative Medicaid Universe	
Total Number of Medicaid Negative Case Actions to be Selected	
Planned Frequency of Sampling	
Universe Size of CHIP Negative Case Actions	
Time Frame of Negative CHIP Universe	
Total Number of CHIP Negative Case Actions to be Selected	
Planned Frequency of Sampling	
Total Universe Size of Medicaid and CHIP Negative Case Actions	
Grand Total of Medicaid and CHIP Negative Case Actions to be Selected	

Appendix 4: Instructions for Completing MEQC Pilot Planning Cover Sheet

Instructions for Submitting MEQC Pilot Planning Document with Cover Sheet:

Please submit planning document no later than November 1 of year in which your state's PERM review ends.

The planning document should be submitted electronically to the MEQC mailbox at: **CMS-MEQC-Inquiries@cms.hhs.gov**

Be sure that the submission includes the name, address, e-mail and phone number of the MEQC Coordinator.

I. MEQC State Data Information

- a. Enter: Name of the state and the date of planning document submission.
- b. Enter: Contact information as indicated (name of contact, email, phone number).

II. Active Cases:

- a. Enter:
 1. Universe size of Medicaid cases from which samples will be taken.
 2. Universe size of CHIP cases from which samples will be taken.
 3. Total universe of Medicaid and CHIP cases in time frame listed below.
- b. Enter the time-frame from which the above universes were selected. If there are different time frames for Medicaid and CHIP or if time frame is not the calendar year after the year of proposal submission, please give rationale for this in the pilot planning document.
- c. Enter the total selected sample of:
 1. Medicaid cases
 2. CHIP cases
 3. Grand Total of Medicaid and CHIP cases selected (**NOTE:** Grand total must be 400 cases or larger, with at least 200 Medicaid cases).

III. Active Case Areas of Focus -- Medicaid

- a. If stratified sampling is done, at least 200 Medicaid active cases must be reviewed.
- b. Enter: Description of each Medicaid area of focus selected.
- c. Enter: Universe size of each Medicaid area of focus selected.
- d. Enter: Sample size of each Medicaid area of focus selected.
- e. If more than 5 Medicaid areas of focus are selected, enter the above information for additional areas on a photocopy of this page that is clearly labeled Medicaid Areas of Focus (Active Cases, cont.).

IV. Active Case Areas of Focus -- CHIP

- a. If stratified sampling is done, enter a description of each CHIP area of focus.
- b. Enter: Universe size of each CHIP area of focus selected.
- c. Enter: Sample size of each CHIP area of focus selected.
- d. If more than 5 CHIP areas of focus are selected, enter the above information for additional areas on a photocopy of this page that is clearly labeled CHIP Areas of Focus (Active Cases, cont.).

V. Negative cases

- a. At least 400 cases must be sampled from the entire universe of negative case actions, of which there must be a minimum of 200 Medicaid and 200 CHIP cases.
- b. Enter:
 1. The total number of negative case actions in the Medicaid universe.
 2. The time frame over which the Medicaid negative case actions are sampled. Provide justification if time frame is not the standard MEQC review period.
 3. The proposed number of Medicaid negative case actions to be sampled.
 4. The planned frequency of sampling.
- c. Enter:
 1. The total number of negative case actions in the CHIP universe.
 2. The time frame over which the CHIP negative case actions are sampled. Provide justification if time frame is not the standard MEQC review period.
 3. The proposed number of CHIP negative case actions to be sampled.
 4. The planned frequency of sampling.
- d. Enter:
 1. The overall size of the universe of negative Medicaid and CHIP case actions.
 2. The grand total of negative Medicaid and CHIP case actions selected.

Appendix 5: List of Cycle 1, 2, and 3 PERM States

Cycle 1	Cycle 2	Cycle 3
Arkansas	Alabama	Alaska
Connecticut	California	Arizona
Delaware	Colorado	District of Columbia
Idaho	Georgia	Florida
Illinois	Kentucky	Hawaii
Kansas	Maryland	Indiana
Michigan	Massachusetts	Iowa
Minnesota	Nebraska	Louisiana
Missouri	New Hampshire	Maine
New Mexico	New Jersey	Mississippi
North Dakota	North Carolina	Montana
Ohio	Rhode Island	Nevada
Oklahoma	South Carolina	New York
Pennsylvania	Tennessee	Oregon
Virginia	Utah	South Dakota
Wisconsin	Vermont	Texas
Wyoming	West Virginia	Washington