

## **Supporting Statement A:**

### **Payment Error Rate Measurement – State Medicaid and CHIP Eligibility**

(CMS-10184, OMB-0938-1012)

#### **A. Background**

This is a reinstatement package. The Payment Error Rate Measurement (PERM) program was developed to implement the requirements of the Improper Payments Information Act (IPIA) of 2002 (Pub. L. 107–300), which requires the head of federal agencies to annually review all programs and activities that it administers to determine and identify any programs that are susceptible to significant erroneous payments. If programs are found to be susceptible to significant improper payments, then the agency must estimate the annual amount of erroneous payments, report those estimates to the Congress, and submit a report on actions the agency is taking to reduce improper payments. IPIA was amended by Improper Payments Elimination and Recovery Act of 2010 (IPERA) (Pub. L. 111–204), the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) (Pub. L. 112–248), and the Payment Integrity Information Act of 2019 (PIIA) (Pub. L. 116-117).

The IPIA directed the Office of Management and Budget (OMB) to provide guidance on implementation; OMB provides such guidance for IPIA, IPERA, IPERIA, and PIIA (collectively, “the improper payment Acts”) in OMB circular A-123 App. C. OMB defines “significant erroneous payments” as annual erroneous payments in the program exceeding both 2.5 percent of program payments and \$10 million (OMB M–06–23, OMB Circular A–123, App. C August 10, 2006). Erroneous payments and improper payments have the same meaning under OMB guidance. For those programs found to be susceptible to significant erroneous payments, federal agencies must provide the estimated amount of improper payments and report on what actions the agency is taking to reduce those improper payments, including setting targets for future erroneous payment levels and a timeline by which the targets will be reached.

The Medicaid program and the Children’s Health Insurance Program (CHIP) were identified as at risk for significant erroneous payments. As set forth in OMB Circular A-136, Financial Reporting Requirements, for IPIA and Recovery Auditing Act reporting, the Department of Health and Human Services reports the estimated improper payment rates for both programs in its annual Agency Financial Report (AFR) to the Congress.

The improper payment rates for Medicaid and CHIP are calculated based on the reviews on three components of both Medicaid and CHIP program. They are: fee-for-service (FFS) claims medical

reviews and data processing reviews, managed care payment data processing reviews, and eligibility reviews. Each of the review components collects different types of information, and the state<sup>1</sup>-specific improper payment rates for each of the review components will be used to calculate an overall state-specific improper payment rate, and the individual state-specific improper payment rates will be used to produce a national improper payment rate for Medicaid and CHIP. The managed care payments data is collected under OMB 0938-0994 (CMS – 10178) and the fee-for-service claims data is collected under OMB 0938-0974 (CMS – 10166). There are no collection instruments for these packages.

### *Statutory and Regulatory Background*

The Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively referred to as the Affordable Care Act) was enacted in March 2010. The Affordable Care Act mandated changes to the Medicaid and CHIP eligibility processes and policies to simplify enrollment and increase the share of eligible persons that are enrolled and covered. Some of the key changes applicable to all states, regardless of a state decision to expand Medicaid coverage, include:

- Use of Modified Adjusted Gross Income (MAGI) methodologies for income determinations and household compositions for most applicants.
- Use of the single streamlined application (or approved alternative) for intake of applicant information.
- Availability of multiple application channels for consumers to submit application information, such as mail, fax, phone, or on-line.
- Use of a HHS-managed data services hub for access to federal verification sources.
- Need for account transfers and data sharing between the state- or federal-Marketplace, Medicaid, and CHIP to avoid rework or confusion by consumers.
- Reliance on data-driven processes for 12 month renewals.
- Use of applicant self-attestation of most eligibility elements as of January 1, 2014, with reliance on electronic third-party data sources for verification, if available.
- Enhanced 90 percent federal financial participation match for the design, development, installation, or enhancement of the state’s eligibility system.

In the December 20, 2019 Further Consolidated Appropriations Act, 2020 (H.R. 1865), CMS required Puerto Rico to establish a plan to satisfy PERM requirements. Puerto Rico will be incorporated

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<sup>1</sup> Instances of “state” utilized within this document will represent “state, district, or territory”, in related context.

officially into the PERM program starting in RY27 (Cycle 3), which covers the payment period between July 1, 2025 through June 30, 2026. Information collection is being revised to include Puerto Rico in the burden assessment.

## **Justification**

### 1. Need and Legal Basis

The Payment Error Rate Measurement (PERM) program was developed to implement the requirements of the Improper Payments Information Act (IPIA) of 2002 (Pub. L. 107–300), which requires the head of federal agencies to annually review all programs and activities that it administers to determine and identify any programs that are susceptible to significant erroneous payments. If programs are found to be susceptible to significant improper payments, then the agency must estimate the annual amount of erroneous payments, report those estimates to the Congress, and submit a report on actions the agency is taking to reduce improper payments. IPIA was amended by Improper Payments Elimination and Recovery Act of 2010 (IPERA) (Pub. L. 111–204), the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) (Pub. L. 112-248), and the Payment Integrity Information Act of 2019 (PIIA) (Pub. L. 116-117).

Section 2(b)(1) of IPERA clarified that, when meeting IPIA and IPERA requirements, agencies must produce a statistically valid estimate, or an estimate that is otherwise appropriate using a methodology approved by the Director of the OMB. IPERIA further clarified requirements for agency reporting on actions to reduce improper payments and recover improper payments.

The collection of information is necessary for CMS to produce national improper payment rates for Medicaid and CHIP as required by Public Law 107-300.

### 2. Information Users

To comply the improper payment Acts, Centers for Medicare & Medicaid Services (CMS) uses a national contracting strategy to produce improper payment rates for Medicaid and CHIP FFS, managed care, and eligibility improper payments. Federal contractors will review States on a rotational basis so that each State will be measured for improper payments, in each program, once and only once every three years. There are two phases of the PERM program, the measurement phase and the corrective action phase. PERM measures improper payments in Medicaid and CHIP and produces State and national-level improper payment rates for each program. The improper payment rates are based on reviews (medical record, data processing, and eligibility reviews) of Medicaid and CHIP FFS and managed care payments made in the year under review following a 12-month period (July 1 through June 30 review period).

CMS created a 17/18-State rotation cycle so that each State will participate in PERM, for both Medicaid and CHIP, once every three years and three types of reviews – medical records, data processing, and eligibility – are measured at the same time. The following table identifies the states in each PERM cycle.

**States Selected for Medicaid Improper Payment Measurements**

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

Since the inception of PERM, States have maintained the responsibility for: developing monthly universes comprised of individuals who are receiving or who were denied/terminated from coverage; selecting statistically-valid samples; conducting eligibility reviews; and reporting findings to CMS. However, experience since the first PERM eligibility cycle in FY 2007 has shown that the PERM eligibility review places a significant burden on state resources, and many states have struggled to meet review timelines because the reviews require substantial staff resources to complete. Further, there is significant opportunity for PERM eligibility review guidance misinterpretation and inconsistent application of the guidance across states. Therefore, the July 5, 2017 Federal Register (82 FR 31158) implemented a federal contractor model to conduct the eligibility reviews on behalf of states in an effort to reduce state burden associated with the PERM program and minimize case review inconsistencies across states in order to improve the case review process and reporting. However, states will still be required to support CMS and the federal contractors in facilitating the PERM eligibility reviews.

For the PERM eligibility review, states will be responsible for providing information to CMS and its federal contractors including:

- Timely and complete access to all necessary state payment systems to facilitate reviews (onsite or remote)
- All medical, eligibility, and other related policies in effect and any quarterly policy updates
- Case documentation to support the eligibility review, as requested by CMS

- A corrective action plan for purposes of reducing erroneous payments in FFS, managed care, and eligibility
- Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining improper payment rates in Medicaid and CHIP

Because the PERM eligibility component review will leverage samples selected from the state fee-for-service and managed care universe submissions, addressed under separate PRA packages, universe collection is not specified as a request for the PERM eligibility reviews.

The eligibility case documentation collected from the States, through submission of hard copy case files and through access to state eligibility systems, will be used by CMS and its federal contractors to conduct eligibility case reviews on individuals who had claims paid on their behalf in order to determine the improper payment rate associated with Medicaid and CHIP eligibility to comply with the IPIA of 2002. Prior to the July 2017 Final Rule being published in response to the Affordable Care Act, states provided CMS only with information about their sampling and review process as well as the final review findings, which CMS has used in each PERM cycle to calculate IPIA-compliant state and federal improper payment rate for Medicaid and CHIP. Given changes brought forth in the July 2017 Final Rule, states will no longer be required to develop eligibility-specific universes, conduct case reviews, and report findings to CMS. A federal contractor will utilize the claims (fee-for-service and managed care universes) to identify a sample of individuals and will be responsible for conducting case reviews to support the PERM measurement.

### 3. Use of Information Technology

This information collection involves the use of electronic submission of information to the extent that States have the technological capability. Electronic communication would be provided to CMS through multiple means of Secure File Transfer Protocol (SFTP) employed by each contractor involved in the program. The statistical contractor utilizes Progress: ipswitch MOVEit Transfer as an SFTP solution and the eligibility review contractor uses MoveIT as an SFTP solution. In states that have document management systems, CMS has required states to provide access to these systems, as well as state eligibility systems, so a federal contractor can access the necessary documentation with minimal burden on the states. In states that maintain hard copy case file documentation, CMS's federal contractor will establish a secure file transfer site that will allow states to submit hard copy data electronically for PERM review. CMS expects that the PERM eligibility will support the use of electronic transfer of information for 100% of case documentation requests.

### 4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained

from any other source. The July 2017 Final Rule further eliminated duplication of effort by eliminating the requirement to perform both PERM and MEQC in a single year. Rather, states will only be required to perform PERM in the required cycle year and will conduct MEQC reviews during the off-PERM years.

5. Small Businesses

The collection of information does not impact small businesses or other small entities.

6. Less Frequent Collection

Failure to acquire this information will prevent CMS from conducting eligibility reviews that support Congressionally-mandated improper payment rate reporting under CMS's approved OMB improper payment Acts' methodology.

7. Special Circumstances

States will be required to submit documentation that supports Medicaid and CHIP eligibility determinations to the federal contractor based on samples selected quarterly. In the event that states must produce documentation to the federal contractor, states will be asked to provide the documentation in less than 30 days in order to support timely review of cases during the PERM cycle. However, states will have the opportunity to submit documentation beyond 30 days up until the PERM cycle cut-off established by CMS.

8. Federal Register/Outside Consultation

A 60-day *Federal Register* notice of the FY 2025 IPPS/LTCH PPS proposed rule (RIN 0938-AV34) was published on May 2, 2024 (89 FR 35934).

9. Payments/Gifts to Respondents

There is no provision for any payment or gift to respondents associated with this reporting requirement.

10. Confidentiality

Confidentiality has been assured in accordance with section 1902(a) (7) of the Social Security Act. We will protect privacy to the extent provided by law.

11. Sensitive Questions

No questions of a sensitive nature are asked.

12. Burden Estimate (Total Hours & Wages)

PERM operates on three separate cycles, where testing and reporting periods can overlap with other cycles. In determining the burden estimate, CMS has taken the overlap into account with regards to the hours estimated. The number of respondents is estimated to be up to 36 programs (17 Medicaid and 17 CHIP programs per states for Cycles 1 & 2, 18 Medicaid and 18 CHIP programs for Cycle 3) in each cycle. Each state is required to respond once every three years for a maximum total of 18 states in each cycle. Each response consists of two programs – Medicaid and CHIP – for a maximum total of 36 programs each cycle (18 states x 2 programs).

**State Distribution for Improper Payment Measurements**

	<b>Program</b>	<b>Cycle 1</b>	<b>Cycle 2</b>	<b>Cycle 3</b>
State Count per Cycle per Program	Medicaid	17	17	18
	CHIP	17	17	18
	<b>Total</b>	<b>34</b>	<b>34</b>	<b>36</b>

Each year, 17-18 States will participate in both the Medicaid improper payment rate measurement and the CHIP improper payment rate measurement. Therefore, estimates were calculated for 36 responses to each request for information. It is estimated that each State will spend up to 750 hours of time annually (when selected), per program, to support this collection of information. The State will conduct the following information, per program (hours estimated for each are listed):

<b>Request</b>	<b>Hours Estimated</b>
<u>Pre-cycle support</u> – submit state policies and review policy collection document, prepare for and participate in the intake meeting, review intake meeting notes, review the eligibility case review planning document	100 hours
<u>Communication &amp; Review support</u> - findings review, difference resolution, appeals process, and as needed meetings/discussions	650 hours
Prepare and submit corrective action plans after improper payment rates are determined for each program. This will be a single submission in the third year after state selection.	250 Hours
<b>Total</b>	<b>1,000 Hours</b>

To derive average costs, we used data from the U.S. Bureau of Labor Statistics’ (BLS) May 2022 National Industry-Specific Occupational Employment and Wage Estimates for State Government (NAICS 999200) ([http://www.bls.gov/oes/current/naics4\\_999200.htm#13-0000](http://www.bls.gov/oes/current/naics4_999200.htm#13-0000)) for the occupation titled ‘Claims Adjusters, Appraisers, Examiners, and Investigators’ (Occupation Code 13-1031). This estimate includes the mean hourly wage (\$32.16) with fringe benefits calculated at 100% totaling \$64.32 per hour.

These costs will vary from State to State depending on many variables including the type of program integrity practices in place, salaries, and pricing

‘Claims Adjusters, Appraisers, Examiners, and Investigators’ (Occupation Code 13-1031)	
Hourly Wage	\$32.16
Fringe Benefits	\$32.16
Total Estimate of Cost per Hour	\$64.32

The maximum annualized total number of hours estimated that may be required to respond to requests for information equals 36,000 hours (1,000 hours X 18 States X 2 programs) for a total estimated cost of \$2,315,520 (\$64.32 x 36,000 hours), or estimated per State cost of \$128,640 (\$64.32 x 2,000 hours).

Ref	Description	Amount
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A	Maximum States per Cycle (Sourced from table above)	18
B	Maximum Programs (Medicaid & CHIP) per Cycle (A x 2)	36
C	Hours estimated for State responses per Program	1,000
D	Maximum Total Hours Estimated per Cycle (B x C)	36,000
E	Total Estimate of Cost per Hour	\$64.32
F	Maximum Total Cost estimate for Cycle (D x E)	\$2,315,520
G	Total Cost estimate per State (F / A)	\$128,640

13. Capital Cost

There are no capital costs associated with this collection of information.

14. Cost to the Federal Government

We have estimated that it will cost \$46 million annually (including optional tasks) for engaging CMS and its Federal contractors to perform all aspects of the PERM review as it relates to the FFS



and managed care components and calculate improper payment rates in a maximum of 36 State programs (18 States for Medicaid and 18 States for CHIP), based on an average of claims reviewed. This is a combined cost estimate is for [0938-0994], [0938-0974], and [0938-1012] as there is much overlap between how these components are performed operationally. This estimate includes total costs to the federal government for CMS and its federal contractors.

15. Changes to Burden

The July 5, 2017, Final Rule (82 FR 31158) shifted costs and a significant hourly burden for conducting eligibility reviews from states (MEQC) to the Federal Government and its contractors (PERM). However, these changes would be largely offset by Federal government savings in reduced payments to states in matching funds. Hourly burden for states was significantly reduced due to the removal of the MEQC collection from the submission, which was estimated at 912,164 hours (946,164 total hours in most recent approved package, less PERM estimate of 34,000 Hours). MEQC has created a separate burden estimate for activities within CMS-319 OMB Control # - 0938-0147. Current burden estimate includes additional burden for inclusion of Puerto Rico in the amount of 2,000 hours for a total burden estimate of 36,000 hours. Prior approved cost of \$26,044,672 has been reduced to \$2,315,520 for a total of \$23,729,152 reduction. due to labor rate changes and reduction of hours mentioned.

16. Publication/Tabulation Dates

The calculated national improper payment rate for both Medicaid and CHIP will be published annually in the AFR.

17. Expiration Date

The expiration date will be displayed on this website <https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm>

18. Certification Statement

There is no exception to the certification statement.

See Supporting Statement B.