Supporting Statement A:

Fee-for-Service Improper Payment Rate Measurement in Medicaid and the Children's Health Insurance Program

(CMS-10166, OMB-0938-0974)

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[1]-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 claims data is collected under OMB 0938-0994 (CMS – 10178) and the eligibility data is collected under OMB 0938-1012 (CMS – 10184). There are no collection instruments for these packages.

Statutory and Regulatory Background

See prior packages for historical background around statutory and regulatory requirements related to the submission. Below are the current statutory and regulatory requirements applicable to the restatement package.

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.

[1] Instances of "state" utilized within this document will represent "state, district, or territory", in related context.

- 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 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.

B. 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 with 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 review States on a rotational basis so that each State is 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

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

PERM has included a FFS claim review since 2006. States are required to provide CMS and its Federal contractors with universe of original FFS claims and payments. The universe is defined by paid dates within the timeframe under review (i.e.,12-month review frame). States are required to provide the FFS claims and payments, per PERM universe requirements, quarterly for a total of four FFS universe submissions for each program (i.e., Medicaid and CHIP, as applicable).

In order to support the FFS claim and payment review, states are also required to provide:

- Timely and complete access to all necessary state payment systems to facilitate reviews (onsite or remote)
- Upon request from CMS, provider contact information that has been verified by the State as current
- All medical, eligibility, and other related policies in effect and any quarterly policy updates

- Data processing systems manuals
- Repricing information for claims that are determined during the review to have been improperly paid
- Information on claims that were selected as part of the sample, but changed in substance after selection, for example, successful provider appeals
- Adjustments made within 60 days of the adjudication dates for the original claims or line items with sufficient information to indicate the nature of the adjustments and to match the adjustments to the original claims or line items
- 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

In addition to the Federal Review Contractor conducting a data processing and medical record review of the FFS claims and payments, the FFS sample selected from the state-submitted universe will also be leveraged to support the PERM eligibility reviews. The Federal Eligibility Review Contractor will review the underlying eligibility of individuals whose FFS claims and payments were sampled as part of the PERM FFS sample.

The information collected from the selected States will be used by Federal contractors to conduct Medicaid and CHIP FFS data processing and medical record reviews on which State-specific improper payment rates will be calculated. The quarterly FFS claims and payments will provide the contractor with the actual claims to be sampled. The systems manuals, provider policies, and other supporting documentation will be used by the federal contractor when conducting the FFS data processing and medical record reviews. Further, the FFS claims and payments sampled for data processing and medical record reviews will serve as the basis for the eligibility reviews. Individuals for whom the state made the FFS claim or payments will have their underlying eligibility reviewed.

3. Use of Information Technology

This information collection involves the use of electronic submission of case related 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 WF_FTP as an SFTP solution and the review contractor uses Accellion: Kiteworks as an SFTP

solution. CMS will not require States to provide information electronically if they do not have secure systems in place to do so. The collection of information does not require a signature from respondents.

4. Duplication of Efforts

Currently, the FFS claim and payment data that meets PERM requirements for Medicaid and CHIP can only be obtained from the States. Medicare Part A and Part B premium payments made by the state are collected directly from CMS to minimize state burden and prevent duplication of effort.

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 data processing, medical, and eligibility reviews that support Congressionally-mandated improper payment rate reporting under CMS's approved OMB improper payment Acts' methodology.

7. Special Circumstances

CMS does not anticipate that states would be required to submit information more often than quarterly. States will provide quarterly claims data at the end of each quarter. States will also be required to submit medical policies at the beginning of being selected and updates on a quarterly basis at the end of each quarter.

8. Federal Register / Outside Consultation

The FY 2025 IPPS/LTCH PPS final rule (RIN 0938-AV34) published on August 28, 2024 (89 FR 68986).

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

Program	**Cycle 1**	**Cycle 2**	**Cycle 3**
Medicaid	17	17	18
CHIP	17	17	18
Total	34	34	36

It is estimated that each state will spend up to 1,650 hours annually, per program, to support this collection of information. The states will provide claims data on a quarterly basis for the following requests, per program:

Request	**Hours Estimated**
Medicaid and CHIP FFS universes and claims detail information for each quarter (4) of the fiscal year	900 hours
Collection and submission of policies with an estimate of 4 submissions - initial submission and quarterly updates.	250 hours
Re-price claims determined to be in error. Errors are expected in less than 10 percent of sampled claims Inform the contractor of claims that were included in the sample but the adjudication decision changed due to the provider appealing the determination and the state overturning the claim Inform the contractor of provider enrollment information to assist in finding a provider associated with a sampled claim so that documentation	500 hours

can be obtained. It is expected that the contractor use common resources such as the internet, the phone book, and directory assistance before consulting the state. Erroneous provider demographic information, where resources other than the state are not available, is expected rare and estimated in less than 1 percent of sampled claims or < 10 requests. Inform the contractor of disputes over findings following the appropriate processes. 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.	
Total	1,650 Hours

The total burden per state per program is estimated to be 1,650 hours. It was determined that the request for medical documentation to substantiate claim submission is not a burden to individual providers nor is the request outside the customary and usual business practices of a Medicaid and/or CHIP provider. It is highly unlikely for a provider to be selected more than once, per program, per year to provide supporting documentation and due to the timeliness of the request for documentation, that information should be readily available and responses should take minimal time. Therefore, this request for information from providers is within the customary and usual business practice of a provider who accepts payment from an insurance provider whether it is a private organization, Medicaid or CHIP.

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) 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. As the FFS component has not changed much since the previous package, the burden estimate was adjusted to reflect small hourly changes based on information solicited from the states.

'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 59,400 hours (1,650 hours X 18 states X 2 programs maximum), for a total cost of $3,820,608 ($64.32 x 59,400 hours), or estimated per State cost of $212,256 ($64.32 x 3,300 hours).

Ref.	Description	Amount
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	1,650
D	Maximum Total Hours Estimated per Cycle (B x C)	59,400
E	Total Estimate of Cost per Hour	$64.32
F	Maximum Total Cost estimate for Cycle (D x E)	$3,820,608
G	Total Cost estimate per State (F / A)	$212,256

The following assumptions were used:

- The estimated number of states needed to produce a national improper payment rate with the confidence and precision to meet the requirements of the improper payment Acts is up to 18 annually, which covers 36 separate programs; 18 for Medicaid and 18 for CHIP.
- The estimated number of claims needed to produce a state specific improper payment rate with the confidence and precision needed to meet improper payment Act's standards is estimated to be around 10,000 for Medicaid and 6,000 for CHIP. The claim samples are allocated to states based on each state's expenditures and prior improper payment rates. Maximum sample allocations to each state is set to 2,000 Medicaid and 1,200 CHIP claims. Minimum sample allocations to each state is set to 328 Medicaid and 208 CHIP claims

- These allocated claims are going to be further stratified, based on service category
- The claims will be sampled over a full fiscal year of adjudicated claims by sampling a weighted number of claims each quarter, with the weight determined by quarterly expenditure data.

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

This is a reinstatement of a previously approved collection with minor adjusted information in the federal contracting costs, as well as, state burden estimates to reflect current practices in meeting PERM requirements, consisting of increased labor cost estimates. Hour estimates for state participation has not changed. Includes additional burden estimate for inclusion of Puerto Rico of 3,300 hours. The total maximum annual burden hours have increased from 56,100 to 59,400 which equates to the 3,300 hours anticipated for Puerto Rico inclusion. The maximum cost has increased from $3,339,072 to $3,820,608 which equates to $481,536.

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 can be found on this website https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm.

18. Certification Statement

There are no exceptions to this certification.

See Supporting Statement B.