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Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 447, and 457
Medicaid Program and Children's Health
Insurance Program (CHIP); Revisions to
the Medicaid Eligibility Quality Control
and Payment Error Rate Measurement
Programs; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 447, and 457

[CMS-6150-P]

RIN 0938-AP69

Medicaid Program and Children's Health Insurance Program (CHIP); Revisions to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement provisions from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) with regard to the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs. This proposed rule would also codify several procedural aspects of the process for estimating improper payments in Medicaid and the Children's Health Insurance Program (CHIP).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 14, 2009.

ADDRESSES: In commenting, please refer to file code CMS-6150-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions for "Comment or Submission" and enter the filecode to find the document accepting comments.

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS-6150-P, P.O. Box 8020, Baltimore, MD 21244-8020.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and

Human Services, *Attention:* CMS-6150-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey (HHH) Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Elizabeth Lindner, (410) 786-7481, or Jessica Woodard, (410) 786-9249.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning

approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

A. Medicaid Eligibility Quality Control Program

The Medicaid Eligibility Quality Control (MEQC) program is set forth in section 1903(u) of the Social Security Act (the Act) and requires States to report to the Secretary the ratio of States' erroneous excess payments for medical assistance to total expenditures for medical assistance. Section 1903(u) of the Act also sets a 3-percent threshold for improper payments in any fiscal year and the Secretary may withhold payments to States based on the amount of improper payments that exceed the threshold.

B. The Improper Payments Information Act of 2002

The Improper Payments Information Act of 2002 (IPIA) (Pub. L. 107-300, enacted on November 26, 2002) requires the heads of Federal agencies to annually review programs they oversee to determine if they are susceptible to significant erroneous payments. If any programs are found to be susceptible to significant improper payments, then the agency must estimate the amount of improper payments, report those estimates to the Congress, and submit a report on actions the agency is taking to reduce erroneous expenditures. The IPIA directed the Office of Management and Budget (OMB) to provide guidance on implementation. 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, Appendix C to OMB Circular A-123, August 10, 2006). 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 them, 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 programs at risk for significant erroneous payments. The Department of Health and Human Services (DHHS) reports the estimated

error rates for the Medicaid and CHIP programs in its annual Performance and Accountability Report (PAR) to Congress.

C. Regulatory History

1. Medicaid Eligibility Quality Control Program

Sections 431.800 through 431.865 set forth the regulatory requirements for States to conduct the annual MEQC measurement. A Medicaid State Operations letter (#93–58) dated July 23, 1993 implemented MEQC pilots that allowed States to conduct special studies that would take the place of the “traditional” MEQC review. States conducting pilot reviews are not subject to the threshold and disallowance provisions under section 1903(u) of the Act as long as the special studies continue.

Currently, the MEQC program consists of the following:

- MEQC traditional—Operating MEQC under 42 CFR 431.800 through 431.865 and selecting a random sample of all Medicaid applicants and enrollees and reviewing them under guidance in the State Medicaid Manual.
- MEQC pilots—Operating MEQC under a special study, a target population and providing oversight to reduce and prevent errors and improve program administration.
- MEQC waivers—Operating MEQC as a part of a CMS approved section 1115 waiver and reviewing beneficiaries included in the research and demonstration project.

2. Payment Error Rate Measurement (PERM) Program

Section 1102(a) of the Act authorizes the Secretary to establish such rules and regulations as may be necessary for the efficient administration of the Medicaid and CHIP programs. The Medicaid statute at section 1902(a)(6) of the Act and the CHIP statute at section 2107(b)(1) of the Act require States to provide information that the Secretary finds necessary for the administration, evaluation, and verification of the States’ programs. Also, section 1902(a)(27) of the Act (and § 457.950 of the regulations) requires providers to submit information regarding payments and claims as requested by the Secretary, State agency, or both. Under the authority of these statutory provisions, we published in the August 27, 2004 **Federal Register** (69 FR 52620) a proposed rule to comply with the requirements of the IPIA and the OMB guidance. The proposed rule set forth provisions for all States to annually estimate improper payments in their

Medicaid and CHIP programs and to report the State-specific error rates for purposes of our computing the national improper payment estimates for these programs.

In the October 5, 2005 **Federal Register** (70 FR 58260), we published an interim final rule with comment period (IFC). The IFC responded to public comments on the proposed rule, and informed the public of our national contracting strategy and of our plan to measure improper payments in a subset of States. Our State selection process ensures that a State is measured once, and only once, every 3 years for each program.

In response to the public comments from the October 5, 2005 IFC, we published a second IFC in the August 28, 2006 **Federal Register** (71 FR 51050), which reiterated our national contracting strategy to estimate improper payments in both Medicaid and CHIP fee-for-service (FFS) and managed care, and set forth and invited further comments on State requirements for estimating improper payments due to errors in Medicaid and CHIP eligibility determinations. We also announced that a State’s Medicaid and CHIP programs would be reviewed in the same year.

In the August 31, 2007 **Federal Register** (72 FR 50490), we published a final rule for the PERM program, which implements the IPIA requirements. The August 31, 2007 final rule responded to the public comments on the August 28, 2006 IFC and finalized State requirements for submitting claims to the Federal contractors that conduct FFS and managed care reviews. The final rule also finalized State requirements for conducting eligibility reviews and estimating payment error rates due to errors in eligibility determinations.

D. Children’s Health Insurance Program Reauthorization Act of 2009

On February 4, 2009, the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111–3) was enacted. (*Please note*, as a result of this legislation, that the program formerly known as the “State Children’s Health Insurance Program (SCHIP)” is now referred to as the “Children’s Health Insurance Program (CHIP)”). Sections 203 and 601 of the CHIPRA relate to the PERM program.

Section 203 of the CHIPRA establishes an error rate measurement with respect to the enrollment of children under the express lane eligibility option. The law directs States not to include children enrolled using the express lane

eligibility option in data or samples used for purposes of complying with the MEQC and PERM requirements. Provisions for States’ express lane eligibility option will be set forth in a future rulemaking document.

Section 601 of the CHIPRA provides for a 90 percent Federal match for Children’s Health Insurance Program (CHIP) spending related to PERM administration and excludes such spending from the 10 percent administrative cap. (Section 2105(c)(2) of the CHIP statute gives States the ability to use an amount up to 10 percent of the CHIP benefit expenditures for outreach efforts, additional services other than the standard benefit package for low-income children, and administrative costs.)

The CHIPRA requires a new PERM rule and delays any calculation of a PERM error rate for CHIP until 6 months after the new PERM rule is effective. Additionally, the CHIPRA provides that States that were scheduled for PERM measurement in fiscal year (FY) 2007 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2007, or may elect instead to consider its PERM measurement conducted for FY 2010 as the first fiscal year for which PERM applies to the State for CHIP. Similarly, the CHIPRA provides that States that were scheduled for PERM measurement in FY 2008 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2008, or may elect instead to consider its PERM measurement conducted for FY 2011 as the first fiscal year for which PERM applies to the State for CHIP.

The CHIPRA requires that the new PERM rule include the following:

- Clearly defined criteria for errors for both States and providers.
- Clearly defined processes for appealing error determinations.
- Clearly defined responsibilities and deadlines for States in implementing any corrective action plans.
- Requirements for State verification of an applicant’s self-declaration or self-certification of eligibility for, and correct amount of, medical assistance under Medicaid or child health assistance under CHIP.
- State-specific sample sizes for application of the PERM requirements.

In addition, the CHIPRA aims to harmonize the PERM and MEQC programs and provides States with the option to apply PERM data resulting from its eligibility reviews for meeting MEQC requirements and vice versa, with certain conditions.

E. CMS Response to the CHIPRA

As required by the CHIPRA, we are proposing revised MEQC and PERM provisions in this proposed rule.

Section 601(b) of the CHIPRA states that “the Secretary shall not calculate or publish any national or State-specific error rate based on the application of the payment error rate measurement (in this section referred to as ‘PERM’) requirements to CHIP until after the date that is 6 months after the date on which a new final rule (in this section referred to as the ‘new final rule’) promulgated after the date of the enactment of this Act and implementing such requirements in accordance with the requirements of subsection (c) is in effect for all States.” The CHIP error rate for the FY 2008 cycle was scheduled to be published in the FY 2009 PAR (in November 2009), which is less than 6 months after the expected promulgation and effective date of this new final rule. Therefore, the publication of any CHIP error rates for FY 2008 is delayed until at least 6 months after the final rule implementing the CHIPRA requirements for PERM is effective.

As noted above, section 601(d) of the CHIPRA provides that States that were scheduled for PERM measurement in FY 2007 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2007, or may elect instead to consider its PERM measurement conducted for FY 2010 as the first fiscal year for which PERM applies to the State for CHIP. In addition, the CHIPRA provides that States that were scheduled for PERM measurement in FY 2008 may elect to accept a CHIP PERM error rate determined in whole or in part on the basis of data for FY 2008, or may elect instead to consider its PERM measurement conducted for FY 2011 as the first fiscal year for which PERM applies to the State for CHIP.

Accordingly, a State measured in the FY 2007 cycle that elects to accept the PERM error rate for its CHIP program determined in whole or in part on the basis of data for FY 2007 is required to notify CMS of its intentions through an acceptance form provided to all States in a State Health Official letter. Similarly, a State measured in the FY 2008 cycle that elects to accept the PERM error rate for its CHIP program determined in whole or in part on the basis of data for FY 2008 is required to notify CMS of its intentions through an acceptance form provided to all States in a State Health Official letter. If a State measured in the FY 2007 or FY 2008 cycles elects to reject the CHIP PERM rate determined during those cycles,

they do not need to notify CMS of this decision. However, information from those cycles will not be used to calculate the State-specific sample sizes and CMS will rely on the standard assumptions for determining sample size.

In order for section 601(d) of the CHIPRA to be read in harmony with the IPIA, which requires a CHIP PERM error rate to be calculated annually, we believe that the appropriate reading of section 601(d) of the CHIPRA, construing the law as a whole and giving effect to all language of the CHIPRA, is that a State may only elect to reject the PERM error rate for the State’s CHIP program for FY 2007 or FY 2008 and instead have its PERM error rate for its CHIP program measured in FY 2010 or FY 2011, respectively. A State scheduled for PERM measurement in FY 2008 will still have its PERM error rate for its Medicaid program measured.

Additionally, States scheduled for PERM measurement in FY 2009 will have the CHIP program reviewed and error rates calculated after the final rule is in effect. Furthermore, the FY 2009 Medicaid measurement is proceeding with no delays as a result of the CHIPRA, and FY 2009 Medicaid error rates will be calculated under the new final rule.

II. Provisions of the Proposed Regulations

As a result of the CHIPRA, we are proposing a nomenclature change to parts 431, 447, and 457. The program formerly known as the “State Children’s Health Insurance Program (SCHIP)” is now referred to as the “Children’s Health Insurance Program (CHIP).” We are also proposing the following revisions to the current PERM provisions:

A. Sample Sizes

Section 601(f) of the CHIPRA requires us to establish State-specific sample sizes for application of the PERM requirements with respect to CHIP for fiscal years beginning with the first fiscal year that begins on or after the date on which the new final rule is in effect for all States, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable: (1) Minimize the administrative cost burden on States under Medicaid and CHIP; and (2) maintain State flexibility to manage such programs.

To comply with the IPIA, the PERM program must estimate a national Medicaid and a national CHIP error rate that covers the 50 States and District of

Columbia. Consistent with OMB’s precision requirements defined in its IPIA guidance, the estimated national error rate for each program must be bound by a 90 percent confidence interval of 2.5 percentage points in either direction of the estimate. Since States administer Medicaid and CHIP and make payments for services rendered under the programs, we collect State-level information at a high level of confidence (the estimated error rate for a State must be bound by a 95 percent confidence interval of 3 percentage points in either direction). To estimate the national error rate, as well as State-specific error rates, reviews are conducted in three areas for both the Medicaid and CHIP programs: (1) Fee-for-service (FFS), (2) managed care, and (3) program eligibility. The FFS and managed care reviews are referred to jointly as the “claims review,” while the program eligibility review is referred to as the “eligibility review.”

Samples of payments made on a FFS and managed care basis for the claims review and samples of beneficiaries for the eligibility review are drawn each year in order to calculate a national error rate that meets the precision requirements described in OMB Guidance (OMB M–06–23, Appendix C to OMB Circular A–123, August 10, 2006). The preferred method is to achieve the precision goal with the smallest sample size possible, so as to reduce the staff burden on States, the Federal government, beneficiaries, and providers. We determined that the most efficient method, statistically, is to draw a sample of States and then draw a sample of payments from the payments made by the sampled States. The process for drawing a sample of States is described in detail in the preamble to the August 31, 2007 final rule (72 FR 50490). We are not proposing modifications to the current approach, which samples 17 States per year for a PERM measurement cycle. This rulemaking addresses the State-specific sample sizes for samples of claims and beneficiaries within a State.

In light of the new CHIPRA requirements, we are proposing to add new § 431.972, to describe more fully the claims sampling procedures used for the claims review, as well as the process for establishing State-specific sample sizes for PERM, although we note that the execution of these responsibilities would remain with CMS and the Federal contractors, not with the States. Under the Secretary’s authority at section 1102(a) of the Act and in order to effectively implement the IPIA, we are also proposing that these sampling

procedures apply to both Medicaid and CHIP.

We are also proposing to revise § 431.978 to provide additional guidance on State Medicaid and CHIP eligibility sample sizes by clarifying the process for establishing State-specific sample sizes.

1. Fee-for-Service (FFS) and Managed Care

a. Universe Definition

In order to implement the IPJA and related requirements (OMB M-06-23, Appendix C to OMB Circular A-123, August 10, 2006) that require Federal agencies to estimate the amount of improper payments in programs with significant erroneous payments (which includes Medicaid and CHIP), in the current § 431.970(a)(1) we require States to submit “[a]ll adjudicated fee-for-service (FFS) and managed care claims information, on a quarterly basis, from the review year,” so that a sample of payments can be reviewed and from the review findings CMS can estimate the amount of improper payments in each program. We propose to remove the word “all” from § 431.970(a)(1) because certain types of payments are excluded from PERM sampling and review for technical reasons. This requirement has been further clarified through instructions issued by CMS to the States.

For the PERM claims review component, the “claims universe” is defined in the new § 431.972 as including payments that were originally paid (paid claims) and for which payment was requested but denied (denied claims) during the Federal fiscal year, and for which there was Federal financial participation (FFP) (or would have been if the claim had not been denied) through Title XIX of the Act (Medicaid) or Title XXI of the Act (CHIP). Depending on the context in which it is used, the claims universe may refer to either all of the adjudicated FFS claims during the fiscal year under review, or all of the managed care capitation payments made during the fiscal year under review, for Medicaid or CHIP.

Due to the significant variation in State systems for processing, paying, and claiming reimbursement for medical services under Medicaid and CHIP, we are not proposing to include a more specific claims universe description in regulation. Rather, States should refer to more detailed claims universe specifications that will be published by CMS in separate instructions at the beginning of each PERM measurement cycle. However, we

are proposing that States must establish controls to ensure that the FFS, managed care, and eligibility universes are complete and accurate. For example, this would include the comparisons between the PERM universes and the State’s CMS-64 and CMS-21 financial reports.

b. Stratification

In FY 2006, we measured only the error rate for the FFS component of Medicaid. To obtain the required precision levels while minimizing the sample size, and therefore reducing the burden on States, the claims universe for FFS payments for Medicaid was stratified by service category and a stratified random sample was drawn for each State. In FY 2007 and beyond, we measure the error rates for Medicaid FFS, Medicaid managed care, CHIP FFS, and CHIP managed care separately (to the extent that a State has each of these programs). We also stratify each universe by dollars rather than service category.

Under this stratification and sampling approach, all payments in each universe are sorted from largest to smallest payment amounts. The payments are then divided into strata such that the total payments in each stratum are the same. For example, if five strata are used, the total dollars in each stratum would equal 20 percent of the total dollars in the universe. The first stratum would contain the highest dollar-valued payments, and the last stratum would contain the smallest dollar-valued payments, including all zero-paid and denied claims (denials have a zero dollar amount, and therefore, would appear in the stratum with the smallest dollar values). An equal number of FFS claims or managed care payments are then drawn from each stratum, which means the sample would include proportionately more high-dollar payments and proportionately fewer low-dollar payments and denials, compared to their representation in the universe. This overweighting of higher-dollar payments (which is taken into account when calculating error rates) enables us to draw a smaller sample size that has a reasonable probability of meeting the precision requirements, compared to a perfectly random sample or a sample stratified by service type. In this manner, we reduce burden on States, the Federal government, beneficiaries, and providers.

c. Fee-for-Service and Managed Care Sample Size

In order to establish State-specific sample sizes, we are proposing that the annual sample size in a State’s first

PERM cycle (referred to as “initial sample” or “base sample”) would be 500 FFS claims and 250 managed care payments.

We determined this initial sample size based on the experience of the PERM pilot study and our requirement that the estimated error rate for a State must be bound by a 95 percent confidence interval of 3 percentage points in either direction. Specifically, the sample size is calculated assuming that the universe is “infinite” and the error rate for FFS is 5 percent and the error rate for managed care is 3 percent. (Once the universe contains more than approximately 10,000 sampling units, it can be treated as if it were infinite. Statistically speaking, beyond a universe of approximately 10,000 sampling units, universe size does not affect sample size.) Using these assumptions and historical information on payment variation in FFS and managed care from previous PERM cycles, we have determined that an annual sample of 500 FFS and 250 managed care payments per State per program should meet our State-level precision requirements with reasonable probability.

However, States with Medicaid or CHIP PERM universes under 10,000 line items or capitation payments can petition CMS for an annual sample size smaller than the base sample size in the initial PERM year or beyond. While the universe can be treated as if it were infinite if its size exceeds 10,000 sampling units, if the total universe from which the total (full year) sample is drawn is less than 10,000 sampling units, the sample size may be reduced by the finite population correction factor. A State that anticipates that the total number of payments in the FFS or managed care universe for either Medicaid or CHIP will be less than 10,000 payments over the Federal fiscal year may notify CMS before the fiscal year being measured and include information on the anticipated universe size for their State. Our contractor will develop a modified sampling plan for that program in that State.

The State-specific annual sample size in the base PERM year is based on an assumed error rate of 5 percent. If a State’s actual PERM error rates in a cycle reveals that precision goals can be achieved in future PERM cycles with either lower or higher sample sizes than indicated by the original assumptions, sample sizes after the first PERM cycle may vary among States according to each State’s demonstrated ability, based on PERM experience, to meet desired precision goals.

In subsequent years, we will provide our contractor with information on each State's error rate and payment variation in the previous cycle. Our contractor will review each State's prior PERM cycle claims error rate and payment variation to determine if a smaller or larger claims sample size will be required to meet the precision goal established for that PERM cycle. Our contractor will develop a State-specific sample size for each program in each State. If information from a previous cycle is not available for a particular State or program within the State, the contractor will use the "base sample" size of 500 FFS claims and 250 managed care payments. For States measured in the FY 2007 or FY 2008 cycle that elect to accept their State-specific CHIP PERM error rate determined during those cycles, FY 2007 or FY 2008 would be considered their first PERM cycle for purposes of sample size calculation for CHIP. Therefore, these States would be considered for an adjusted sample size in their next year of measurement after the publication of the new final rule. For States measured in the FY 2007 or FY 2008 cycle that elect to reject their State-specific CHIP PERM error rate determined during those cycles, information from those cycles would not be used to calculate the State-specific sample sizes and the "base sample" size of 500 FFS claims and 250 managed care payments would be used.

We are proposing to establish a maximum sample size for Medicaid or CHIP FFS or managed care of 1,000 claims. Additionally, as discussed above, a State with a claims universe of less than 10,000 sampling units in a program may notify CMS and the annual sample size will be reduced by the finite population correction factor for any PERM cycle. We believe that by taking into consideration prior cycle PERM error rates, as well as the finite population correction factor in establishing State-specific sample sizes, the States' administrative cost burden will be reduced and the program will be manageable at the State level.

2. Eligibility

The eligibility sampling requirements are described in § 431.978. The universe for the eligibility component is case-based, not claims-based. The case as a sampling unit only applies to the eligibility component. For PERM eligibility, the "universe" is the total number of Medicaid or CHIP cases, which, as discussed later in this proposed rule, is comprised of all beneficiaries, both individuals and families. The eligibility sampling plan and procedures state that the total

eligibility sample size must be estimated to achieve within a 3 percent precision level at 95 percent confidence interval for the eligibility component of the program.

For PERM eligibility, the initial sample size is calculated under the assumption that the error rate is 5 percent and the universe is greater than 10,000 total cases. This means that the desired precision requirements will be achieved with a high probability if the actual error rate is 5 percent or less. For this reason, an annual sample of 504 active cases and 204 negative cases should be selected in a State's base PERM year to meet State-level precision requirements with a high probability. Appendix D of the PERM Eligibility Review Instructions elaborates on the theory of sample size at the State-level for the dollar-weighted active case error rates, and is on the CMS Web site at http://www.cms.hhs.gov/perm/downloads/PERM_Eligibility_Review_Guidance.pdf.

Eligibility sampling is performed by the States, and States have the opportunity to adjust their eligibility sample size based on the eligibility error rate in the previous PERM cycle. After a State's base PERM year, we will determine, with input from the State, a sample size that will meet desired precision goals at lower or higher sample sizes based on the outcome of the State's previous PERM cycle. The sample size could either increase or decrease given the results of the previous year. We are proposing to establish a maximum sample size for eligibility at 1,000 cases. States must submit an eligibility sampling plan by August 1st before the fiscal year being measured and include a proposed sample size for their State. Our contractor will review and approve all eligibility sampling plans. The State must notify CMS that it will be using the same plan from the previous review year if the plan is unchanged. However, we will review State sampling plans from prior cycles in each PERM cycle to ensure that information is accurate and up-to-date. States will be asked for revisions when necessary.

As in the claims universe, States with PERM eligibility universes under 10,000 cases can notify CMS for a reduced eligibility sample size for either the base year or any subsequent PERM cycle.

Additionally, section 203 of the CHIPRA describes the State option to enroll children in CHIP based on findings of an express lane agency that has conducted simplified eligibility determinations. Under section 203(a)(13)(E) of the CHIPRA, an error rate measurement will be created with

respect to the enrollment of children under the express lane eligibility option. The law directs States not to include children enrolled using the express lane eligibility option starting April 1, 2009, in data or samples used for purposes of complying with MEQC and PERM requirements. Provisions for States' express lane option will be set forth in a future rulemaking document.

We are proposing to revise § 431.814 and § 431.978 to reflect the changes and clarifications specified above.

B. Error Criteria

Under the PERM program, we identify improper payments through claims reviews and eligibility reviews. For the claims review, we perform the following: (1) A data processing review of a sample of FFS and managed care payments to ensure the payments were processed and paid in accordance with State and Federal policy; and (2) a medical review of a sample of FFS payments to ensure that the services were medically necessary, coded correctly, and provided and documented in accordance with State and Federal policy. For the eligibility review, we rely on States to review a sample of beneficiary cases to ensure that they were eligible for the program and for any services received and paid for by Medicaid or CHIP (as applicable). The PERM eligibility review also considers negative cases (cases where eligibility was denied or terminated). A negative case is in error if the case was improperly denied or incorrectly terminated. However, because there are no payments associated with these cases, only a case error rate is calculated. These errors are not factored into the PERM error rate, which is a payment error rate.

Under the IPIA, to be considered an improper payment, the error made must affect payment under applicable Federal policy and State policy. Improper payments include both overpayments and underpayments. A payment is also considered improper where it cannot be discerned whether the payment was proper as a result of insufficient or lack of documentation.

Consistent with the IPIA, the PERM error rate itself does not distinguish between "State" and "provider" errors; all dollars in error identified through PERM reviews contribute to the State error rate. In practice, the data processing and eligibility reviews focus on determinations made by State systems and personnel, while the medical review focuses on documentation maintained and claims submitted by providers.

Section 601(c)(1)(A) of the CHIPRA requires CMS to promulgate a new final rule that includes clearly defined criteria for errors for both States and providers. Accordingly, we are proposing to add § 431.960, “Types of payment errors,” to clarify that State or provider errors for purposes of the PERM error rate must affect payment under applicable Federal policy and State policy, and to generally categorize data processing errors and eligibility determination errors as State errors and medical review errors as provider errors. The data processing errors, medical review errors, and eligibility determination errors may include, but are not limited to, the types of improper payments discussed below.

1. Claims Review Error Criteria

a. Data Processing Errors (Generally State Errors)

i. Duplicate Item

The sampled line item/claim is an exact duplicate of another line item/claim that was previously paid (for example, same patient, same provider, same date of service, same procedure code, and same modifier).

ii. Non-Covered Service

The State policy indicates that the service is not payable by Medicaid or CHIP under the State plan and/or the beneficiary is not in the coverage category for that service.

iii. Fee-for-Service Claim for a Managed Care Service

The beneficiary is enrolled in a managed care organization that should have covered the service, but the sampled service was inappropriately paid by the Medicaid or CHIP FFS component.

iv. Third-Party Liability

The service should have been paid by a third party and was inappropriately paid by Medicaid or CHIP.

v. Pricing Error

Payment for the service does not correspond with the pricing schedule on file for the date of service.

vi. Logic Edit

A system edit was not in place based on policy or a system edit was in place but was not working correctly and the claim line was paid (for example, incompatibility between gender and procedure).

vii. Data Entry Errors

A claim/line item is in error due to clerical errors in the data entry of the claim.

viii. Managed Care Rate Cell Error

The beneficiary was enrolled in managed care and payment was made, but for the wrong rate cell.

ix. Managed Care Payment Error

The beneficiary was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.

x. Other Data Processing Error

Errors not included in any of the above categories.

b. Medical Review Errors (Generally Provider Errors)

i. No Documentation

The provider did not respond to the request for records within the required timeframe.

ii. Insufficient Documentation

There is not enough documentation to support the service.

iii. Procedure Coding Error

The procedure was performed but billed using an incorrect procedure code and the result affected the payment amount.

iv. Diagnosis Coding Error

According to the medical record, the diagnosis was incorrect and resulted in a payment error—as in a Diagnosis Related Group (DRG) error.

v. Unbundling

The provider separately billed and was paid for the separate components of a procedure code when only one inclusive procedure code should have been billed and paid.

vi. Number of Unit(s) Error

The incorrect number of units was billed for a particular procedure/service, National Drug Code (NDC) units, or revenue code.

vii. Medically Unnecessary Service

The service was medically unnecessary based upon the documentation of the patient’s condition in the medical record.

viii. Policy Violation

A policy is in place regarding the service or procedure performed and medical review indicates that the service or procedure is not in agreement with the documented policy.

ix. Administrative/Other Medical Review Error

A payment error was determined by the medical review but does not fit into one of the other medical review error

categories, including State-specific non-covered services.

c. Eligibility Errors (Generally State Errors)

i. Not Eligible

An individual beneficiary or family is receiving benefits under the program but does not meet the State’s categorical and financial criteria in the first 30 days of eligibility being verified.

ii. Eligible With Ineligible Services

An individual beneficiary or family meets the State’s categorical and financial criteria for receipt of benefits under the Medicaid or CHIP program but was not eligible to receive particular services. An example of “eligible with ineligible services” would be a person eligible under the medically needy group who received services not provided to the medically needy group.

iii. Undetermined

A beneficiary case subject to a Medicaid or CHIP eligibility determination review under PERM and which a definitive determination of eligibility could not be made.

iv. Liability Overstated

The beneficiary paid too much toward his liability amount or cost of institutional care and the State paid too little.

v. Liability Understated

Beneficiary paid too little toward his liability amount or cost of institutional care and the State paid too much.

vi. Managed Care Error 1

Ineligible for managed care—Upon verification of residency and program eligibility, the beneficiary is enrolled in managed care but is not eligible for managed care.

vii. Managed Care Error 2

Eligible for managed care but improperly enrolled—Beneficiary is eligible for both the program and for managed care but not enrolled in the correct managed care plan as of the month eligibility is being verified.

viii. Improper Denial

The application for program benefits was denied by the State for not meeting the categorical and/or financial eligibility requirements but upon review is found to be eligible.

ix. Improper Termination

Based on a completed redetermination, the State determines an existing beneficiary no longer meets the program’s categorical and/or

financial eligibility requirements and is terminated but upon review is found to still be eligible.

2. Definitions

Based on the criteria identified in section II.B.1 of this proposed rule, we are proposing to add the following definitions for “provider error” and “State error” to § 431.958.

Provider error includes, but is not limited to, an improper payment made due to lack of or insufficient documentation, incorrect coding, improper billing (for example, unbundling, incorrect number of units), a payment that is in error due to lack of medical necessity, or evidence that the service was not provided in compliance with documented State or Federal policy.

State error includes, but is not limited to the following:

- A payment that is in error due to incorrect processing (for example, duplicate of an earlier payment, payment for a non-covered service, payment for an ineligible beneficiary).
- Incorrect payment amount (for example, incorrect fee schedule or capitation rate applied, incorrect third-party liability applied).
- A payment error resulting from services being provided to an individual who—
 - ++ Was ineligible when authorized or when he or she received services;
 - ++ Was eligible for the program but was ineligible for certain services he or she received; or
 - ++ Had not met applicable beneficiary liability requirements when authorized eligible or paid too much toward actual liability.
 - ++ Had a lack of sufficient documentation to make a definitive determination of eligibility or ineligibility.

C. Self-Declaration of Eligibility

Section 601(c)(2) of the CHIPRA requires that the payment error rate determined for a State shall not take into account payment errors resulting from the State’s verification of an applicant’s self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant’s self-declaration or self-certification satisfies the requirements for such process applicable under regulations promulgated by the Secretary or otherwise approved by the Secretary.

Accordingly, we are proposing to specify in the new § 431.960 that the dollars paid in error due to the eligibility error is the measure of the

payment error. A State eligibility error does not result from the State’s verification of an applicant’s self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant’s self-declaration or self-certification satisfies the requirements for such process applicable under regulations at § 457.380 of this chapter, in CMS approved State Plans, or otherwise approved by the Secretary.

We also propose to modify § 431.980 to provide review requirements for acceptable self-declaration. We would also modify the PERM eligibility instructions, found at http://www.cms.hhs.gov/perm/downloads/PERM_Eligibility_Review_Guidance.pdf. These instructions, which clarify and provide additional guidance in implementing the regulations, reflect the new review procedures for self-declaration.

Currently, States are required to review the case record and independently verify elements of eligibility where evidence is missing, or outdated and likely to change, or otherwise as needed. The instructions and the regulation would provide that “a self-declaration statement for Medicaid or CHIP is acceptable verification for the PERM reviews for elements of eligibility in which State policy allows for self-declaration. A self-declaration statement must be—

- Present in the record;
- Not outdated (more than 12 months old);
- In a valid, State approved format; and
- Consistent with other facts in the case record.

A State may verify eligibility through a new self-declaration statement, depending on State policies on self-declaration. We propose that if a new self-declaration statement cannot be obtained for the PERM review, the State may verify eligibility using third party sources, for example, documentation listed in section 7269 of the State Medicaid Manual. Verifying a self-declaration statement with third party verification when a beneficiary does not provide a new self-declaration statement is the only new review procedure being added. After all minimum efforts listed in the eligibility instructions have been exhausted, a case should be cited as Undetermined if sufficient documentation cannot be obtained to complete the eligibility review. We are proposing that these Undetermined cases would not be included in the State-specific payment error rate.

However, we are proposing to specify in the new § 431.960 that these errors be tracked nationally by including these Undetermined cases in the national program payment error rates.

D. Difference Resolution and Appeals Process

Section 601(c)(1)(B) of the CHIPRA requires CMS to include in the new final rule for PERM a clearly defined process for appealing error determinations by review contractors or State agency and personnel responsible for the development, direction, implementation, and evaluation of eligibility reviews and associated activities.

1. Medical and Data Processing Review

The October 5, 2005 IFC established the difference resolution process, which is codified at § 431.998. Medical reviews and data processing reviews for FFS and managed care payments are conducted by an independent Federal contractor. States supply relevant policies but do not participate in the review; States are notified of all error findings. The difference resolution process is the mechanism by which a State may try to resolve with the Federal contractor differences in the Federal contractor’s error findings; the State may appeal to CMS if it cannot resolve the difference in findings with the Federal contractor.

In accordance with the CHIPRA, we are providing more detail in this proposed rule by proposing the timeline associated with the difference resolution and CMS appeals processes. We are also revising the heading of § 431.998 to read, “Difference resolution and appeal process,” which more accurately describes the regulation.

We are proposing to revise § 431.998 to explain that the State may file, in writing, a request with the Federal contractor to resolve differences in the Federal contractor’s findings based on medical or data processing reviews of FFS and managed care claims in Medicaid or CHIP within 10 business days after the disposition report of claims review findings is posted on the contractor’s Web site. Additionally, the State may appeal to CMS for a final resolution within 5 business days from the date the contractor’s finding as a result of the difference resolution is posted on its Web site.

In addition to establishing the timeline for the difference resolution and appeal processes, we are proposing to eliminate the dollar threshold for engaging in the CMS appeals process. Section 431.998 currently provides that States may apply to the Federal contractor to resolve differences in

findings and may appeal to CMS for final resolution for any claims in which the State and Federal contractor cannot resolve the difference in findings, as long as the difference in findings is in the amount of \$100 or more. We established the \$100 threshold in order to prevent *de minimis* disputes and to ensure that appeals to CMS were substantial enough to warrant reconsideration. We were also concerned that a large volume of small-dollar appeals would prevent the States from receiving timely decisions on their appeals.

Information from the FY 2006 and FY 2007 PERM cycles on the number of total claims (including those with errors less than \$100) submitted to the Federal contractor for difference resolution and on the number appealed to CMS for final resolution suggests that the volume of appeals will not substantially increase if CMS allows appeals of errors of less than \$100. Because all errors regardless of their dollar amount ultimately contribute to a State's error rate and hence the national error rate, we are proposing to remove the \$100 threshold set forth in § 431.998(b)(1).

2. Eligibility

As stated in the current PERM regulations at § 431.974(a)(2), personnel responsible for PERM eligibility sampling and review "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." The intent of this provision was to ensure the independence of the review in order to achieve an unbiased error rate. We provided further clarification in the preamble of the August 2007 final rule, indicating that the agency responsible for PERM could be under the same umbrella agency that oversees policy, operations and determinations but the two agencies cannot report to the same supervisor.

We would further clarify that qualified staff with knowledge of State eligibility policies may be used to conduct the eligibility reviews, but the staff that is chosen must be independent from the staff that oversees policy and operations. Further, the PERM eligibility instructions ask States to provide assurance that the agency or contracting entity responsible for the eligibility reviews is independent of the State agency responsible for eligibility determination and enrollment. The State is responsible for ensuring the integrity of the eligibility reviews, but we do not preclude the independent State agency from sharing or reporting

the eligibility findings to other agencies or stakeholders.

Provided that agency independence could cause a difference in findings between the independent agency and other stakeholder agencies at the State level, we propose that appeals for eligibility review findings should be conducted in accordance with the State's appeal process, as eligibility reviews are conducted at the State level.

In consideration of States that may not have a State appeals process in place, we are also proposing to make State findings available to each respective State's stakeholders (that is, the State Medicaid or CHIP agency), with certain limitations, for the period between the final monthly payment findings submission and eligibility error rate calculation, for example, April 15th through June 15th after the fiscal year being measured or according to the eligibility timeline. We propose facilitating documentation exchange between the State Medicaid or CHIP agency and the independent State agency conducting the PERM eligibility reviews to resolve differences. If any eligibility appeals issues involve Federal policy, States can appeal to CMS for resolution. If our decision causes an erroneous payment finding to be made, any resulting recoveries will be governed by § 431.1002.

Other stakeholder agencies may document their differences in writing to the independent State agency for consideration. If resolutions of differences occur during the PERM cycle, eligibility findings can be updated to reflect the resolution. If differences are not resolved by the deadline for eligibility findings to be submitted to CMS (July 1), the documentation of the difference can be submitted to CMS for consideration no sooner than 60 days and no later than 90 days after the deadline for eligibility findings.

We are also seeking comment on other ways that we can implement an eligibility appeals process for which we can provide consistent oversight.

E. Harmonization of Medicaid Eligibility Quality Control (MEQC) and PERM Programs

1. Options for Applying PERM and MEQC Data

Section 601(e)(2) of the CHIPRA requires that, once this final rule is effective for all States, States will be given the option to elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the State for a fiscal year under section 1903(u) of the Act, to

substitute data resulting from the application of the PERM requirements to the State for data obtained from the application of the MEQC requirements to the State with respect to a fiscal year. Because under section 601(b) of the CHIPRA, there shall be no calculation or publication of any national or State-specific CHIP error rates until 6 months after the final rule becomes effective, States will not have the option to substitute PERM data for MEQC data until 6 months after this final rule is effective.

We considered several interpretations of the CHIPRA requirements that would allow States the option to substitute MEQC data for PERM data and vice versa for purposes of the PERM Medicaid eligibility reviews, but would also retain two separate, independent processes (MEQC and PERM), which are governed by separate statutes and regulations. As PERM is required to meet specific statistical precision requirements and the MEQC error rate is not, we do not believe it is feasible to incorporate the MEQC error rate into a State's overall PERM error rate. Therefore, we interpret "data" as the sample, eligibility review findings, and payment findings as measured under MEQC or PERM. We will calculate separate rates for each program. We are proposing to amend § 431.806 and § 431.812 of the MEQC regulations. These proposed amendments would provide for the State's option in its PERM year to use their samples, eligibility findings and payment findings as measured using PERM sampling and review requirements to meet their MEQC review requirement. States operating under MEQC waivers and pilot programs cannot use this option. Therefore, to provide requirements for implementing a pilot or waiver MEQC program, we are proposing revisions to the MEQC regulation at § 431.812. We are proposing that States that choose to substitute PERM data for MEQC data, would still have two eligibility error rates calculated — one for MEQC using MEQC measurement requirements and one for PERM using PERM requirements. We are proposing to revise § 431.806 of the MEQC regulations to require that a State plan provide a State plan amendment for States opting to use PERM for MEQC in a State's PERM cycle.

We are proposing to amend § 431.812 of the MEQC regulation to provide that States substituting PERM data for MEQC data must use a sampling plan that meets the requirements of § 431.978 of the PERM regulation and perform active

case reviews in accordance with § 431.980 of the PERM regulation.

We are proposing that States with CHIP stand alone programs will only have the option to substitute PERM Medicaid data to meet MEQC requirements under § 431.812(a) through (e) since CHIP stand alone programs are not reviewed under MEQC.

We are also proposing that States with Medicaid and Title XXI Medicaid expansion programs may use Medicaid and CHIP PERM reviews to meet the MEQC requirements described under § 431.812(a) through (e), as both Medicaid and Title XXI Medicaid expansion programs are reviewed under MEQC. States with Title XXI Medicaid expansion programs must combine their Medicaid and CHIP PERM findings to calculate one MEQC error rate. The data must be kept separate for purposes of calculating the PERM error rate.

In addition, we are proposing that States with combination CHIP programs, in which a portion of their CHIP cases are under a stand alone program and a portion of their CHIP cases are under a Title XXI Medicaid expansion program, may use the PERM Medicaid eligibility reviews and the portion of the PERM CHIP eligibility reviews under Title XXI Medicaid expansion programs to meet their MEQC requirement. The Federal contractor will combine the CHIP case findings under the Title XXI Medicaid expansion program and CHIP stand alone findings to calculate one PERM CHIP error rate. The Title XXI Medicaid expansion portion of the PERM data must be included with the Medicaid PERM data to calculate the MEQC error rate.

Section 601(e)(3) of the CHIPRA provides that for purposes of satisfying the requirements of the PERM regulation relating to Medicaid eligibility reviews, a State may elect to substitute data obtained through MEQC reviews conducted in accordance with section 1903(u) of the Act for data required for purposes of PERM requirements, but only if the State MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the States. The CHIPRA's general effective date of April 1, 2009 applies to this provision. Therefore, as of April 1, 2009, States have the option to substitute MEQC data for PERM data so long as the MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the States.

We interpret "broad, representative sample of Medicaid applicants or enrollees" to mean that States must develop the MEQC universe according

to requirements at § 431.814 in order to consider the option to use one program's findings to meet the requirements for the other. Under § 431.814, States must sample from a universe of all Medicaid and Title XXI Medicaid expansion beneficiaries (except for the exclusions provided in § 431.814(c)(4)). States operating MEQC pilots or waivers will need to continue operating PERM separately from MEQC.

We are proposing that States with CHIP stand alone programs only have the option to substitute Medicaid MEQC data to meet the PERM Medicaid eligibility review requirement, as CHIP stand alone is not reviewed under the MEQC review.

We are also proposing that States with Title XXI Medicaid expansion programs may use their MEQC reviews described in § 431.812(a) through (e) to meet both the PERM Medicaid and CHIP eligibility review requirements, as both Medicaid and Title XXI Medicaid expansion are reviewed under MEQC. Title XXI Medicaid expansion data must be separated from the MEQC Medicaid data to calculate a PERM CHIP error rate.

We are also proposing that States with combination programs in which a portion of their CHIP cases are under a stand alone program and a portion of their CHIP cases are under a Title XXI Medicaid expansion program may use the MEQC reviews described under § 431.812 (a) through (e) to meet the PERM Medicaid eligibility review requirement and the portion of the PERM CHIP eligibility review requirement under Title XXI Medicaid expansion. However, the stand alone portion of the CHIP universe must remain separate and stratified, as defined in § 431.978(d)(3), as CHIP stand alone is not a part of the harmonization of PERM and MEQC. The Federal contractor, who we are proposing will calculate State eligibility error rates, will combine the Title XXI Medicaid expansion and CHIP stand alone findings to calculate one PERM CHIP error rate.

In addition, we are proposing to amend § 431.980 to allow for States in their PERM year the option to use their MEQC samples, eligibility findings, and payment findings to meet their PERM eligibility review requirement. MEQC reporting requirements to the CMS Regional Offices remain the same, including reporting the error findings for the two 6-month review periods, but States will also be required to comply with the PERM eligibility reporting deadlines by posting error findings to the PERM Error Rate Tracking (PERT) Web site or other electronic eligibility findings repository specified by CMS.

We are proposing that States that choose to substitute MEQC data for PERM data, will still have two eligibility error rates calculated—one for MEQC using MEQC measurement requirements and one for PERM using PERM requirements.

States that choose to substitute MEQC data must ensure that the Medicaid and Title XXI Medicaid expansion sample sizes meet PERM precision requirements when they are separated. States must also note that if using MEQC data, any cases sampled under § 431.814(c)(4) must be excluded from the PERM sample. For example, State-only funded cases, should be reported separately.

States that choose to substitute MEQC or PERM data should note that although two error rates are calculated, only the MEQC error rate will be subject to disallowances under section 1903(u) of the Act. PERM does not have a threshold for eligibility errors and any improper payments identified during the eligibility measurement are subject to recovery according to § 431.1002 of the regulations.

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

We are also seeking comments on the following alternative process for the substitution of MEQC and PERM data: States would select one annual sample that meets MEQC minimum sample requirements and PERM confidence and precision requirements. The State would conduct both an MEQC review and a PERM review on each applicable case. This would ensure a clear distinction between an MEQC error and a PERM eligibility error, and will be the basis for the MEQC error rate and the PERM eligibility error rate. We are also seeking comment on other possible methods for substitution of data.

States that choose to substitute MEQC data may only claim the regular administrative matching rate for performing the MEQC procedures for Medicaid and Title XXI Medicaid expansion cases. The 90 percent PERM enhanced administrative matching rate will only be applicable to States conducting PERM reviews for CHIP cases.

2. Definition of a Case

Section 431.958 currently defines a case as an "individual beneficiary." States are required to sample and conduct eligibility and payment reviews for an individual beneficiary even if the State grants eligibility at the family

level. However, sampling at the individual beneficiary level has proven to be difficult for States from a programming perspective.

Many States receive, review, and grant eligibility based on an application for an entire family, which could be for one person or multiple people. Dividing the family unit for PERM eligibility sampling has been difficult for States to achieve. In addition, the CHIPRA requires MEQC and PERM harmonization to reduce the burden on States.

The MEQC regulation, at § 431.804, defines an active case, in pertinent part, as an “individual [beneficiary] or family.” Changing the definition of a case for PERM eligibility to include both individual beneficiaries and families will support the harmonization process by making it easier for States to utilize their new option of substituting PERM data for MEQC data, and vice versa.

Therefore, we are proposing to revise the definition of a case in § 431.958 to mean an individual or family.

3. Error Rate Calculation: State Responsibility for Calculating Error Rates

Section 431.988 requires, as part of the PERM eligibility review process, for States to calculate and report case and payment error rates for active cases and case error rates for negative cases. As originally envisioned, States retained responsibility for sampling cases, conducting eligibility reviews, collecting payment information for errors, and calculating eligibility error rates. States were to report final eligibility error rates to CMS, which will forward the information to the Federal contractor for inclusion in the overall State and national error rates.

In practice, States have found it difficult to calculate the eligibility error rates. In most cases, States lack the necessary statistical or technical expertise to execute the error rate calculation formulas provided in the PERM eligibility instructions. During the FY 2007 cycle, the Federal contractor provided substantial technical assistance to the States to assist them in conducting these calculations including developing a spreadsheet that States could use to perform the required calculations. Several States requested that, rather than have the Federal contractor provide a spreadsheet that the States merely populate and return to CMS, the Federal contractor perform the required calculations.

Initially, we did not consider it feasible for the Federal contractor to conduct the PERM eligibility error rate

calculations because the States conduct the reviews and maintain the case and payment error data. However, during FY 2007, we developed a centralized reporting system for monthly case and payment error data. The Federal contractor can access the centralized system to conduct the eligibility error rate calculations.

Given the difficulties States have experienced in calculating the PERM eligibility error rates and that there are now mechanisms and processes for the Federal contractor to calculate these error rates, we are proposing to revise § 431.988(b)(1) and (b)(2) by replacing “rates” with “data” to read as follows: “The agency must report by July 1 following the review year, information as follows: (1) Case and payment error data for active cases; and (2) Case error data for negative cases.”

We maintain that this approach will reduce the burden on the States and more accurately reflect current practice, which is that the Federal contractor calculates the eligibility error rates used in the generation of the PERM error rate, as well as the State and national-level error rates. We will continue to require States to report data to the centralized reporting system and will provide States with a spreadsheet or similar calculator that can be used to estimate their own eligibility error rates, but will not require States to submit these estimates to CMS.

F. Corrective Action Plans

Section 601(c)(1)(C) of the CHIPRA requires CMS to provide defined responsibilities and deadlines for States in implementing corrective action plans.

1. Corrective Action Plan Due Dates

We are proposing to revise § 431.992 to provide that States would be required to submit to CMS and implement the corrective action plan for the fiscal year it was reviewed no later than 60 calendar days from the date the State’s error rate is posted to the CMS Contractor’s Web site. State error rates will be posted to the Web site no later than November 15 of each calendar year.

2. Types of Plans

In addition to measuring programs at risk for significant improper payments, the IPIA also requires a report on Federal agency actions taken to reduce improper payments. Since States administer Medicaid and CHIP and make payments for services rendered under these programs, it is necessary that States take corrective actions to reduce improper payments at the State level. We issued a State Health Official

letter in October 2007 to all States detailing the corrective action process under PERM, which can be found on the CMS PERM Web site at http://www.cms.hhs.gov/PERM/Downloads/Corrective_Action_Plan.pdf.

The corrective action process is the means by which States take administrative actions to reduce errors which cause misspent Medicaid and CHIP dollars. The corrective action process involves analyzing findings from the PERM measurement, identifying root causes of errors and developing corrective actions designed to reduce major error causes, and trends in errors or other factors for purposes of reducing improper payments.

Development, implementation, and monitoring of the corrective action plan are the responsibility of the States. In order to develop an effective corrective action plan, States must perform data and program analysis, as well as plan, implement, monitor, and evaluate corrective actions. We are proposing to revise § 431.992 to define States’ responsibilities for these activities as explained below.

(1) *Data Analysis*—States must conduct data analysis such as reviewing clusters of errors, general error causes, characteristics, and frequency of errors. States must also consider improper payments associated with errors. Data analysis may sort the predominant payment errors and number of errors as follows:

- Type—general classification (for example, FFS, managed care, eligibility).
- Element—specific type of classification (for example, no documentation errors, duplicate claims, ineligible cases due to excess income).
- Nature—cause of error (for example, providers not submitting medical records, lack of systems edits, unreported changes in income that caused ineligibility). For the eligibility component, States must analyze both active and negative case errors and also causes for undetermined case findings.

(2) *Program Analysis*—States must review the findings of the data analysis to determine the specific programmatic causes to which errors are attributed (for example, a provider’s lack of understanding of section 1902(a)(27) of the Act and § 457.950 of the regulations requiring providers to submit information regarding payments and claims as requested by the Secretary, State agency, or both) and to identify root error causes. The States may need to analyze the agency’s operational policies and procedures and identify those policies or procedures that contribute to errors, for example,

policies that are unclear, or there is a lack of operational oversight at the local level.

(3) *Corrective Action Planning*—States must determine the corrective actions to be implemented that address the root error causes.

(4) *Implementation and Monitoring*—States must implement the corrective actions in accordance with an implementation schedule. States must develop an implementation schedule for each corrective action initiative and implement those actions. The implementation schedule must identify major tasks, key personnel responsible for each activity, and must include a timeline for each action including target implementation dates, milestones, and monitoring.

(5) *Evaluation*—States must evaluate the effectiveness of the corrective action by assessing improvements in operations, efficiencies, and the incidence of payment errors or number of errors. Subsequent corrective action plans that are submitted as a result of the State's next measurement must include updates on the following previous actions: (1) Effectiveness of implemented corrective actions using concrete data; (2) discontinued or ineffective actions, and actions not implemented and what actions were used as replacements; (3) findings on short-term corrective actions; and (4) the status of the long-term corrective actions.

In addition, we are proposing that CMS would review and approve the corrective action plans submitted by States, and may request regular updates on the approved corrective actions. We are soliciting public comments on the timeline and process associated with this review and approval.

III. Additional Issues Soliciting Public Comments

We are exploring options for the future management of the CHIP and Medicaid PERM programs. We welcome input on components of the program. When submitting input, please address the following details:

- Data source;
- Sampling methodology;
- Medical and data processing reviews;
- Reporting;
- Appeals.

We are soliciting public comments and may consider them in a future rulemaking effort.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-

day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Review Procedure (§ 431.812)

Section 431.812(a)(1) states that except as provided in paragraph (a)(2) of this section, the agency must review all active cases selected from the State agency's lists of cases authorized eligible for the review month, to determine if the cases were eligible for services during all or part of the month under review, and, if appropriate, whether the proper amount of recipient liability was computed. In § 431.812, proposed paragraph (g) states that a State in its PERM year may elect to substitute the random sample of selected cases, eligibility review findings, and payment review findings obtained through PERM reviews conducted in accordance with § 431.980 of the regulations for data required in this section, where the only exclusions are those set forth in § 431.978(d)(1) of this regulation. The burden associated with this requirement is the time and effort necessary to complete the review of active cases. The burden associated with this requirement is currently approved under OMB control number 0938–0147 with an October 31, 2009, expiration date.

States in their PERM year that elect to substitute PERM data to meet the requirements of § 431.812 would significantly reduce the burden associated with reviewing active cases for MEQC. The burden associated with the information collection requirements contained in proposed § 431.812(g) is the time and effort necessary for a State to substitute the random sample of

selected cases, eligibility review findings, and payment review findings obtained through PERM reviews conducted in accordance with § 431.980. Currently, we believe 19 States (12 Medicaid States and 7 CHIP States) can elect the data substitution and comply with this requirement. We estimate that it would take each agency 10,055 hours to comply with the information collection requirements. In subsequent years, we expect that more States will elect to substitute data from section § 431.980 to meet this requirement so we are estimating the maximum burden for 34 States (17 Medicaid States and 17 CHIP States). The total burden associated with the requirements in proposed § 431.812(g) is 341,870 hours.

Although the review burden would be significantly reduced, States would still be required to report PERM and MEQC findings separately. The additional burden is explained in the section below for § 431.980. We will submit a revised information collection request for 0938–0147 to account for the increased burden as a result of the requirements proposed in § 431.812(g).

B. ICRs Regarding MEQC Sampling Plan and Procedures (§ 431.814)

Section 431.814 states that an agency must submit a basic MEQC sampling plan (or revisions to a current plan) that meets the requirements of this section to the appropriate CMS Regional Office for approval at least 60 days before the beginning of the review period in which it is to be implemented. The burden associated with this requirement is the time and effort necessary to draft and submit a new sampling plan or to draft and submit a revised sampling plan to the appropriate CMS Regional Office. While this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0146 with an October 31, 2009, expiration date.

C. ICRs Regarding PERM Eligibility Sampling Plan and Procedures (§ 431.978)

In § 431.978, the proposed revisions to paragraph (a) discuss the requirements for sampling plan approval. Specifically, the proposed revision to § 431.978(a)(1) states that for each review year, the agency must submit a State-specific Medicaid or CHIP sampling plan (or revisions to a current plan) for both active and negative cases to CMS for approval by the August 1 before the review year and must receive approval of the plan before implementation. The proposed revision to § 431.978(a)(2) further explains that the agency must notify CMS that it

would be using the same plan from the previous review year if the plan is unchanged.

The burden associated with the information collection requirements contained in § 431.978(a) is the time and effort necessary for State agencies to draft and submit the aforementioned information to CMS. While this requirement is subject to the PRA, the associated burden is approved under OMB control number 0938–1012 with a January 31, 2010, expiration date.

D. ICRs Regarding Eligibility Review Procedures (§ 431.980)

Proposed § 431.980(d) states that unless the State has elected to substitute MEQC data for PERM data under paragraph (f) of this section, the agency must complete the following.

Specifically, proposed § 431.980(d)(iii) requires a State to examine the evidence in the case file that supports categorical and financial eligibility for the category of coverage in which the case is assigned, and independently verify information that is missing, older than 12 months and likely to change, or otherwise as needed, to verify eligibility. Section 431.980(d)(vi) states that the elements of eligibility in which State policy allows for self declaration can be verified with a new self-declaration statement. Proposed § 431.980(vii) contains the requirements for a self-declaration statement.

The burden associated with the requirements contained in proposed § 431.980 is the time and effort necessary for a State agency to complete the aforementioned requirements. While this requirement is subject to the PRA, the associated burden is currently approved under OMB control number 0938–1012.

Proposed § 431.980(f)(1) allows for a State in its PERM year to elect to substitute the random sample of

selected cases, eligibility review findings, and payment reviews findings obtained through MEQC reviews conducted in accordance with section 1903(u) of the Act to meet its PERM eligibility review requirement. The substitution of the MEQC data is allowed as long as the State MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the State. In addition, as stated in proposed § 431.980(f)(2), the MEQC samples must also meet PERM confidence and precision requirements.

The burden associated with the information collection requirements contained in proposed § 431.980(f) is the time and effort necessary for a State to collect, review, and submit the MEQC data as part of meeting its PERM eligibility review requirement. States that elect to substitute MEQC data to complete the requirements of § 431.980 would significantly reduce the burden associated with reviewing active cases for PERM. Although the review burden would be eliminated, States would still be required to report PERM and MEQC findings separately. Currently we believe 19 States (12 Medicaid States and 7 CHIP States) can elect the data substitution and comply with this requirement. We estimate that it would take each agency 10,500 hours to comply with the information collection requirements. In subsequent years, we expect that more States will elect to substitute data from section § 431.812 to meet this requirement so we are estimating the maximum burden for 34 States (17 Medicaid States and 17 CHIP States). The total burden associated with the requirements in proposed § 431.980(f) is 357,000 hours.

We also propose adding additional burden as stated above. States must report PERM and MEQC findings separately and will use an estimated 2

hours per required form to reformat PERM or MEQC data into the appropriate forms. We are adding an additional 98 hours for each State to reformat MEQC data into the appropriate PERM eligibility forms and 98 hours for each State to compile PERM eligibility data to submit on the appropriate MEQC forms. We will submit a revised information collection request for 0938–1012 to account for the increased burden as a result of the requirements proposed in § 431.980(f).

E. ICRs Regarding Corrective Action Plan (§ 431.992)

The proposed revisions to § 431.992(a) specify that State agencies must submit to CMS a corrective action plan to reduce improper payments in its Medicaid and CHIP programs based on its analysis of the error causes in the FFS, managed care, and eligibility components. In § 431.992(b), we are proposing to revise this section to require States to submit a corrective action plan to CMS for the fiscal year it was reviewed no later than 60 days from the date the State’s error rate is posted to the CMS Contractor’s Web site. As proposed in § 431.992(c), States will be required to implement corrective actions in accordance with their corrective action plans as submitted to CMS. Proposed § 431.992(d) details the required components of a corrective action plan.

The burden associated with the information collection requirements in proposed revisions to § 431.992 is the time and effort necessary for States to develop corrective action plans, submit the plans to CMS, and implement corrective actions as dictated by their corrective plans. While these requirements are subject to the PRA, the burden is approved under the OMB control numbers shown in Table 1.

TABLE 1—OMB CONTROL NUMBERS

| Program component | OMB control No. | Expiration date |
|-----------------------|-----------------|-----------------|
| Fee-for-Service | 0938–0974 .. | 02/29/2012 |
| Managed Care | 0938–0994 .. | 09/30/2009 |
| Eligibility | 0938–1012 .. | 01/31/2010 |

F. ICRs Regarding Difference Resolution and Appeal Process (§ 431.998)

As proposed in § 431.998(a), a State may file, in writing, a request with the Federal contractor to resolve differences in the Federal contractor’s findings based on medical or data processing reviews on FFS and managed care claims in Medicaid and CHIP within 10

business days after the disposition report of claims review findings is posted on the contractor’s Web site. The written request must include a factual basis for filing the difference and it must provide the Federal contractor with valid evidence directly related to the error finding to support the State’s

position that the claim was properly paid.

Proposed § 431.998(b) states that for a claim in which the State and the Federal contractor cannot resolve the difference in findings, the State may appeal to CMS for final resolution within 5 business days from the date the contractor’s finding as a result of the

difference resolution is posted on its Web site.

Proposed § 431.998(c) states that for eligibility error determinations made by agencies or personnel functionally and physically separate from the State agencies and personnel that are responsible for Medicaid and CHIP policy and operations, the State may appeal error determinations by filing a request with the appropriate State agencies. If no appeals process is in place at the State level, differences in findings must be documented in writing for the independent State agency to consider. Any unresolved differences

may be addressed by CMS between the final month of payment data submission and error rate calculation. CMS may facilitate documentation exchange to assist in resolving difference at the State level. Any changes in error findings must be reported to CMS by the deadline for submitting final eligibility review findings. Any appeals of determinations based on interpretations of Federal policy may be referred to CMS.

The burden associated with the information collection requirements contained in proposed § 431.998(a) through (c) is the time and effort

necessary to draft and submit requests for difference resolution proceedings and determination appeals. We believe the burden associated with these requirements are exempt from the PRA under 5 CFR 1320.4. Information collected subsequent to an administrative action is not subject to the PRA.

G. OMB Control Number(s) for Reporting and Recordkeeping Burden

The burden is approved under the OMB control numbers stated in Table 2.

TABLE 2—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

| Regulation section(s) | OMB control No. | Respondents | Responses | Burden per response (hours) | Total annual burden (hours) |
|-----------------------|-----------------|-------------|---------------------|-----------------------------|-----------------------------|
| § 431.812 | 0938-0147 | 10 | 120 | 8 | 1 960 |
| § 431.814 | 0938-0146 | 10 | 20 | 24 | 480 |
| § 431.978 | 0938-1012 | 34 | 1,360 | 393.875 | 535,670 |
| § 431.980 | 0938-1012 | 34 | 1,360 | 393.875 | ¹ 535,670 |
| § 431.992 | 0938-0974 | 34 | 34 | 840 | 28,560 |
| | 0938-0994 | 36 | ² 18,000 | 1 | 23,400 |
| | 0938-1012 | 34 | 1,360 | 393.875 | ³ 535,670 |
| Total | | | | | 589,070 |

¹ We are submitting a revision of the currently approved ICR for the proposed information collection requirements in this section of the regulation.

² The currently approved number of responses is 23,400; however, the value is incorrect due to an arithmetic error. We have already submitted an 83-C Change Worksheet to OMB to correct the error.

³ For the purpose of totaling the burden associated with the ICRs in this regulation, the annual burden associated with OMB control number 0938-1012 is counted only once.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, [CMS-6150-P].

Fax: (202) 395-6974; or

E-mail: OIRA_submission@omb.eop.gov.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993, as further amended), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). For the reasons discussed below, we have determined that this proposed rule is not a major rule.

1. Federal Contracting Cost Estimate

We have estimated that it will cost \$14.7 million annually for engaging Federal contractors to review FFS and managed care claims and calculate error rates in 34 State programs (17 States for Medicaid and 17 States for CHIP). We estimated these costs as follows:

In the August 31, 2007 final rule, we estimated the Federal cost for use of Federal contractors conducting the FFS and managed care measurements to be \$19.8 million annually. Due to more recent data acquired through our experience with Federal contractors in the FY 2007, FY 2008, and FY 2009 PERM cycles, we were able to produce a more accurate estimate by taking the average of Federal contracting costs for the three cycles and including anticipated future PERM cycle costs. The error rate measurements for 34 State programs (17 States for Medicaid and 17 States for CHIP) would cost approximately \$14,682,777 in Federal funds for the Federal contracting cost.

2. State Cost Estimate for Fee-for-Service and Managed Care Reviews

We estimated that total State cost for FFS and managed care reviews for 34 State programs is \$6.2 million

(\$4,309,490 in Federal cost and \$1,846,924 in State cost). This cost estimate is based on the cost for States to prepare and submit claims universe information for both FFS and managed care payments, prepare and submit claims details and provider information for sampled records, submit State program policies and updates on a quarterly basis, cooperate with Federal contractors during data processing review, participate in the difference resolution and appeals process, and prepare and submit a corrective action plan for claims errors. These costs are estimated as follows:

We estimated that the annualized number of hours required to respond to requests for required claims information for FFS and managed care review for 34 State programs will be 112,200 hours (3,300 hours per State per program). At the 2009 general schedule GS-12-01 rate of pay that includes fringe and overhead costs (\$54.87/hour), we calculated a cost of \$6,156,414 (\$4,309,490 in Federal cost and \$1,846,924 in State cost). This cost estimate includes the following estimated annualized hours: (1) Up to 1,800 hours required for States to develop and submit required claims and capitation payments information; (2) up to 500 hours for the collection and submission of policies; and (3) up to 1,000 hours for States to cooperate with CMS and the Federal contractors on other aspects of the claims review and corrective action process.

Therefore, the total annual estimate of the State cost for 34 State programs to submit information for FFS and managed care reviews and participate with CMS and Federal contractors is \$6,156,414 (\$4,309,490 in Federal cost and \$1,846,924 in State cost).

3. Cost Estimate for Eligibility Reviews

Beginning in FY 2007, States review eligibility in the same year they are selected for FFS and managed care reviews in Medicaid and CHIP. We estimated that total cost for eligibility review for 34 State programs is \$24,588,344 (\$17,211,841 in Federal cost and \$7,376,503 in State cost). This cost estimate is based on the cost for States to submit information to CMS and the cost for States to conduct eligibility reviews and report rates to CMS. These costs are estimated as follows:

We estimated in the information collection section, that the annualized number of hours required to respond to requests for information for the eligibility review (for example, sampling plan, monthly sample lists, the eligibility corrective action report) for

34 State programs will be 108,800 hours (3,200 hours per State per program). At the 2009 general schedule GS-12-01 rate of pay that includes fringe and overhead costs (\$54.87/hour), we calculated a cost of \$5,969,856 (\$4,178,899 in Federal cost and \$1,790,957 in State cost). This cost estimate includes the following estimated annualized hours: (1) Up to 1,000 hours required for States to develop and submit a sampling plan; (2) up to 1,200 hours for States to submit 12 monthly sample lists detailing the cases selected for review; and (3) up to 1,000 hours for States to submit a corrective action plan for purposes of reducing the eligibility payment error rate. For the eligibility review and reporting of the findings, we estimated that each State would need to review an annual sample size of 504 active cases to achieve a 3 percent margin of error at a 95 percent confidence interval level in the State-specific error rates. We also estimated that States would need to review 204 negative cases to produce a case error rate that met similar standards for statistical significance. We estimated that for 34 State programs the annualized number of hours required to complete the eligibility case reviews and report the eligibility-based error data to CMS would be 339,320 hours (9,980 hours per State, per program). At the 2009 general schedule GS-12-01 rate of pay that includes fringe and overhead costs (\$54.87/hour), we calculated a cost of \$18,618,488 (\$13,032,942 in Federal cost and \$5,585,547 in State cost).

Therefore, the total annual estimate of the cost for 34 State programs to submit information and to conduct the eligibility reviews and report the error rate to CMS is \$24,588,344 (\$17,211,841 in Federal cost and \$7,376,503 in State cost).

The CHIPRA requires CMS to provide States in their PERM year the option to use PERM data to meet the MEQC requirements described in section 1903(u) of the Act, and the option to use MEQC data described in § 431.812 to meet the PERM eligibility review requirement. While the intent is to reduce redundancies and cost burden between the two programs and their review requirements, States that substitute findings may incur more costs to implement changes to their PERM or MEQC sampling and review procedures.

4. Cost Estimate for Total PERM Costs

Based on our estimates of the costs for the FFS, managed care and eligibility reviews for both the Medicaid and CHIP programs at approximately \$45.4 million (\$36,204,108 in Federal cost and

\$9,223,428 in State cost), this rule does not exceed the \$100 million or more in any 1 year criterion for a major rule, and a regulatory impact analysis is not required.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than \$7.0 million to \$34.5 million in any 1 year). Individuals and States are not included in the definition of a small entity.

Providers could be required to supply medical records or other similar documentation that verified the provision of Medicaid or CHIP services to beneficiaries as part of the PERM reviews, but we anticipate this action would not have a significant cost impact on providers. Providers would only need to provide medical records for the FFS component of this program. A request for medical documentation to substantiate a claim for payment would not be a burden to providers nor would it be outside the customary and usual business practices of Medicaid or CHIP providers. Not all States would be reviewed every year and medical records would only be requested for FFS claims, so it is unlikely for a provider to be selected more than once per program per measurement cycle to provide supporting documentation, particularly in States with a large Medicaid or CHIP managed care population. If a provider is, in fact, selected more than once per program to provide supporting documentation it would not be outside customary and usual business practices.

In addition, the information should be readily available and the response should take minimal time and cost since the response would merely require gathering the documents and either copying and mailing them or sending them by facsimile. The request for medical documentation 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, Medicare, Medicaid, or CHIP and should not have a significant impact on the provider's operations. Therefore, the Secretary has determined that this proposed rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory

impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds.

These entities may incur costs due to collecting and submitting medical records to the contractor to support medical reviews; but, like any other Medicaid or CHIP provider, we estimate these costs would not be outside the limit of usual and customary business practices. Also, since the sample is randomly selected and only FFS claims are subject to medical review, we do not anticipate that a great number of small rural hospitals would be asked for an unreasonable number of medical records. As stated before, a State will be reviewed only once, per program, every 3 years and it is unlikely for a provider to be selected more than once per program to provide supporting documentation. Therefore, the Secretary has determined that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold is approximately \$133 million. This proposed rule does not impose costs on States to produce the error rates for FFS and managed care payments, but requires States and providers to submit claims information and medical records and cooperate with Federal contractors during the review so that error rates can be calculated.

Based on our estimates of State participation burden for both Medicaid and CHIP, for 34 States (17 States per Medicaid and 17 States for CHIP), we calculated that the annual burden for these States for the PERM program is approximately \$9,223,428 in State costs for both Medicaid and CHIP. The combined costs of both programs total approximately \$542,555 for each of the 17 States. Thus, we do not anticipate State costs to exceed \$133 million. Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or

otherwise has Federalism implications. This proposed rule requires States to prepare and submit claims universe information for both FFS and managed care payments, prepare and submit claims details and provider information for sampled records, submit State program policies and updates on a quarterly basis, cooperate with Federal contractors during data processing reviews, participate in the difference resolution and appeals process, and prepare and submit a corrective action plan for claims errors. We estimated that the burden to respond to requests for claims information for the FFS and managed care measurement for Medicaid and CHIP for 34 State programs (17 States for Medicaid and 17 States for CHIP) will be \$6,156,414 (\$4,309,490 in Federal cost and \$1,846,924 in State cost).

This proposed rule also require States selected for review to submit an eligibility sampling plan, monthly sample selection information, summary review findings, State error rate data, and other information in order for CMS to calculate the eligibility State-specific and national error rates. We estimated that the burden to conduct the eligibility measurement for Medicaid and CHIP for 34 State programs (17 States for Medicaid and 17 States for CHIP) will be approximately \$24,588,344 (\$17,211,841 in Federal cost and \$7,376,503 in State cost). As a result, we assert that this regulation will not have a substantial impact on State or local governments.

B. Anticipated Effects

This proposed rule is intended to measure improper payments in Medicaid and CHIP. States would implement corrective actions to reduce the error rate, thereby producing savings over time. These savings cannot be estimated until after the corrective actions have been monitored and determined to be effective, which can take several years.

C. Alternatives Considered

This proposed rule reflects changes required by the CHIPRA. Therefore, we considered only applying additional changes to the CHIP component of PERM (except in instances where CHIPRA specifically requires the provision to apply to Medicaid and CHIP). However, in order to maintain a consistent measurement process for the Medicaid and CHIP programs, we did not choose this alternative. No other alternatives were considered since the modifications were required by Federal statute.

D. Conclusion

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 431

Grant programs—health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

Subpart P—Quality Control

2. In 42 CFR part 431, revise all references to “SCHIP” to read “CHIP”.
3. Amend § 431.636 by revising all references to “State Children’s Health Insurance Program” to read “Children’s Health Insurance Program.”
4. Section 431.806 is amended by—
 - A. Redesignating paragraph (b) as paragraph (c).
 - B. Adding new paragraph (b).
 - C. Revising redesignated paragraph (c).

The addition and revision read as follows:

§ 431.806 State plan requirements.

* * * * *

(b) *Use of PERM data.* A State plan must provide for operating a Medicaid eligibility quality control program that is in accordance with § 431.978 through § 431.980 of this part to meet the requirements of § 431.810 through § 431.822 of this subpart when a State is in their PERM year.

(c) *Claims processing assessment system.* Except in a State that has an approved Medicaid Management Information System (MMIS) under

subpart C of part 433 of this subchapter, a State Plan must provide for operating a Medicaid quality control claims processing assessment system that meets the requirements of § 431.836 of this subpart.

5. Section 431.812 is amended by adding new paragraphs (f) and (g) to read as follows:

§ 431.812 Review procedures.

* * * * *

- (f) MEQC pilot reviews and waivers. (1) A State may elect to conduct MEQC pilot reviews using an alternative methodology or a focused Medicaid population with CMS approval. (2) States must submit a pilot proposal at least 60 days before planned implementation of the pilot reviews. (3) The State must receive CMS approval of its plan before it is implemented.

(g) Substitution of PERM data. A State in its Payment Error Rate Measurement (PERM) year may elect to substitute the random sample of selected cases, eligibility review findings, and payment review findings obtained through PERM reviews conducted in accordance with § 431.980 of this part for data required in this section, if the only exclusions are those set forth in § 431.978(d)(1) of this part.

6. Section 431.814 is amended by revising paragraph (c)(4) to read as follows:

§ 431.814 Sampling plan and procedures.

* * * * *

- (c) * * * (4) States must exclude from the MEQC universe all of the following: (i) SSI beneficiaries whose eligibility determinations were made exclusively by the Social Security Administration under an agreement under section 1634 of the Act. (ii) Individuals in foster care or receiving adoption assistance whose eligibility is determined under Title IV-E of the Act. (iii) Individuals receiving Medicaid under programs that are 100 percent Federally-funded. (iv) Individuals whose eligibility was determined under a State's option under section 1902(e)(13) of the Act.

* * * * *

Subpart Q—Requirements for Estimating Improper Payments in Medicaid and CHIP

7. Amend § 431.950 by revising the reference to "State Children's Health Insurance Program" to read "Children's Health Insurance Program."

8. Section § 431.954 is amended by adding a sentence to the end of paragraph (a) to read as follows:

§ 431.954 Basis and scope.

(a) * * * This subpart also implements the provisions of section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) which requires that the new PERM regulations include the following: Clearly defined criteria for errors for both States and providers; clearly defined processes for appealing error determinations; clearly defined responsibilities and deadlines for States in implementing any corrective action plans; requirements for State verification of an applicant's self-declaration or self-certification of eligibility for, and correct amount of, medical assistance under Medicaid or child health assistance under CHIP; and State-specific sample sizes for application of the PERM requirements.

* * * * *

- 9. Section 431.958 is amended by— A. Adding definitions for the terms "Annual sample size," "Children's Health Insurance Program," "Provider error," and "State error" in alphabetical order. B. Removing the definition of "State Children's Health Insurance Program." C. Revising the definition of "Case". The additions and revision read as follows:

§ 431.958 Definitions and use of terms.

* * * * *

Annual sample size means the number of fee-for-service claims, managed care payments or eligibility cases necessary to meet precision requirements in a given PERM cycle. Case means an individual beneficiary or family enrolled in Medicaid or CHIP or who has been denied enrollment or has been terminated from Medicaid or CHIP.

* * * * *

Children's Health Insurance Program (CHIP) means the program authorized and funded under Title XXI of the Act.

* * * * *

- Provider error includes, but is not limited to one of the following: (1) An improper payment made due to lack of or insufficient documentation. (2) Incorrect coding. (3) Improper billing (for example, unbundling, incorrect number of units). (4) A payment that is in error due to lack of medical necessity. (5) Evidence that the service was not provided in compliance with documented State or Federal policy.

* * * * *

State error includes, but is not limited to one of the following:

- (1) A payment that is in error due to incorrect processing (for example, duplicate of an earlier payment, payment for a non-covered service, payment for an ineligible beneficiary). (2) Incorrect payment amount (for example, incorrect fee schedule or capitation rate applied, incorrect third party liability applied). (3) A payment error resulting from services being provided to an individual who— (i) Was ineligible when authorized or when he or she received services; (ii) Was eligible for the program but was ineligible for certain services he or she received; or (iii) Had not met applicable beneficiary liability requirements when authorized eligible or paid too much toward actual liability.

* * * * *

10. Section 431.960 is added to read as follows:

§ 431.960 Types of payment errors.

(a) General rule. State or provider errors identified for the Medicaid and CHIP improper payments measurement under the Improper Payments Information Act of 2002 must affect payment under applicable Federal policy and State policy.

(b) Data processing errors. (1) A processing error is an error resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System, related systems, or outside sources of provider verification.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid is the dollar measure of the payment error.

(c) Medical review errors. (1) A medical review error is an error resulting in an overpayment or underpayment that is determined from a review of the provider's documentation, the State's written policies, and a comparison with the information presented on the claim.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid is the dollar measure of the payment error.

(d) Eligibility errors. (1) An eligibility error is an error resulting from services being provided to an individual who—

- (i) Was ineligible when authorized or when he or she received services;

(ii) Was eligible for the program but was ineligible for certain services he or she received;

(iii) Had not met applicable beneficiary liability requirements when authorized as eligible or paid too much toward actual liability; or

(iv) Had a lack of or insufficient documentation in the case record to make a definitive determination of eligibility or ineligibility.

(2) The dollars paid in error due to the eligibility error is the measure of the payment error.

(3) A State eligibility error does not result from the State's verification of an applicant's self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant's self-declaration or self-certification satisfies the requirements for such process applicable under regulations at § 457.380 of this chapter, in CMS approved State plans, or otherwise approved by the Secretary.

Requirements for acceptable self-declaration for eligibility reviews are described at § 431.980(d)(1) and (d)(2).

(4) Negative case errors are errors 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.

(5) No payment errors are associated with negative cases.

(e) *Errors for purposes of determining the national error rates.* The Medicaid and CHIP national error rates include but are not limited to the errors described in paragraphs (b) through (d)(1) of this section.

(f) *Errors for purposes of determining the State error rates.* (1) The Medicaid and CHIP State error rates include but are not limited to, the errors described in paragraphs (b) through (d)(1)(iii) of this section.

(2) Undetermined cases, as described in paragraph (d)(1)(iv) of this section, cited in the eligibility reviews are excluded from State-specific payment error rates if the errors satisfy the criteria in paragraph (d)(3) of this section.

(g) *Error codes.* CMS may define different types of errors within the above categories for analysis and reporting purposes. Only dollars in error will factor into a State's PERM error rate.

11. Section 431.970 is amended by revising paragraph (a)(1) to read as follows:

§ 431.970 Information submission requirements.

(a) * * *

(1) Adjudicated fee-for-service (FFS) or managed care claims information or both, on a quarterly basis, from the review year;

* * * * *

12. Section 431.972 is added to read as follows:

§ 431.972 Claims sampling procedures.

(a) *Claims universe.* The PERM claims universe includes payments that were originally paid (paid claims) and for which payment was requested but denied (denied claims) during the Federal fiscal year, and for which there is Federal financial participation (FFP) (or would have been if the claim had not been denied) through Title XIX (Medicaid) or Title XXI (CHIP).

(b) *Sample size.* CMS estimates a State's annual sample size for claims review at the beginning of the PERM cycle.

(1) *Precision and confidence levels.* The annual sample size must be estimated to achieve a State-level error rate within a 3 percent precision level at 95 percent confidence interval for the claims component of the PERM program, unless the precision requirement is waived by CMS on its own initiative.

(2) *Base year sample size.* The annual sample size in a State's first PERM cycle (the "base year") is—

(i) Five hundred fee-for-service claims and 250 managed care payments drawn from the claims universe; or

(ii) If the claims universe of fee-for-service claims or managed care capitation payments from which the annual sample is drawn is less than 10,000, the State may request to reduce its sample size by the finite population correction factor for the relevant PERM cycle.

(3) *Subsequent year sample size.* In PERM cycles following the base year:

(i) CMS considers the error rate from the State's previous PERM cycle to determine the State's annual sample size for the current PERM cycle.

(ii) The maximum sample size is 1,000 fee-for-service or managed care payments, respectively.

(iii) If a State measured in the FY 2007 or FY 2008 cycle elects to reject its State-specific CHIP PERM rate determined during those cycles, information from those cycles will not be used to calculate its annual sample size in subsequent PERM cycles and the State's annual sample size in FY 2010 or FY 2011 is 500 fee-for-service and 250 managed care payments.

13. Section 431.978 is amended by—

A. Revising paragraphs (a) through (c).
B. Revising paragraphs (d)(1)(i) and (ii).

The revisions read as follows:

§ 431.978 Eligibility sampling plan and procedures.

(a) *Plan approval.* For each review year, the State must—

(1) Submit its Medicaid or CHIP sampling plan (or revisions to a current plan) for both active and negative cases to CMS for approval by the August 1 before the review year; and

(2) Have its sampling plan approved by CMS before the plan is implemented.

(b) *Maintain current plan.* The State must do the both of the following:

(1) Keep its plan current, for example, by making adjustments to the plan when necessary due to fluctuations in the universe.

(2) Review its plan each review year. If it is determined that the approved plan is—

(i) Unchanged from the previous review year, the State must notify CMS that it is using the plan from the previous review year; or

(ii) Changed from the previous review year, the State must submit a revised plan for CMS approval.

(c) *Sample size.* (1) *Precision and confidence levels.* Annual sample size for eligibility reviews must be estimated to achieve within a 3 percent precision level at 95 percent confidence interval for the eligibility component of the program.

(2) *Base year sample size.* Annual sample size for each State's base year of PERM is—

(i) Five hundred and four active cases and 204 negative cases drawn from the active and negative universes; or

(ii) If the active case universe or negative case universe of Medicaid or CHIP beneficiaries from which the annual sample is drawn is less than 10,000, the sample size may be reduced by the finite population correction factor for the relevant PERM cycle.

(3) *Subsequent year sample size.* In PERM cycles following the base year the annual sample size may increase or decrease based on the State's prior results of the previous cycle PERM error rate information. The State may provide information to CMS in the eligibility sampling plan due to CMS by the August 1 prior to the start of the fiscal year to support the calculation of a reduced annual sample size for the next PERM cycle.

(i) CMS considers the error rate from the State's previous PERM cycle to determine the State's annual sample size for the current PERM cycle.

(ii) The maximum sample size is 1,000 for the active cases and negative cases, respectively.

(iii) If the active case universe or negative case universe of Medicaid or CHIP beneficiaries from which the annual sample is drawn is less than 10,000, the sample size may be reduced by the finite population correction factor for the relevant PERM cycle.

(iv) If a State measured in the FY 2007 or FY 2008 cycle elects to reject its PERM CHIP rate as determined during those cycles, information from those cycles is not used to calculate the State's sample size in subsequent PERM cycles and the State's sample size in FY 2010 or FY 2011 is 504 active cases and 204 negative cases.

(d) * * *

(1) * * *

(i) *Medicaid*. (A) The Medicaid active universe consists of all active Medicaid cases funded through Title XIX for the sample month.

(B) The following types of cases are excluded from the Medicaid active universe:

(1) Cases for which the Social Security Administration, under a section 1634 agreement with a State, determines Medicaid eligibility for Supplemental Security Income recipients.

(2) All foster care and adoption assistance cases under Title IV-E of the Act are excluded from the universe in all States.

(3) Cases under active fraud investigations.

(4) Cases in which eligibility was determined under section 1902(e)(13) of the Act for States' express lane option.

(C) If the State cannot identify cases under active fraud investigations for exclusion from the universe previous to the sample selection, the State shall drop these cases from review if they are selected in the sample and are later determined to be under active fraud investigation at the time of selection.

(ii) *CHIP*. (A) The CHIP active universe consists of all active case CHIP and Title XXI Medicaid expansion cases that are funded through Title XXI for the sample month.

(B) The following types of cases are excluded from the CHIP active universe:

(1) Cases under active fraud investigation.

(2) Cases in which eligibility was determined under section 1902(e)(13) of the Act for States' express lane option.

(C) If the State cannot identify cases that meet the exclusion criteria specified in paragraph (d)(1)(ii)(B) of this section before sample selection, the State must drop these cases from review if it is later determined that the cases meet

the exclusion criteria specified in paragraph (d)(1)(ii)(B) of this section.

* * * * *

14. Section 431.980 is amended by—
A. Revising the introductory text of paragraph (d)(1).

B. In paragraph (d)(1)(i) and (ii), removing the “;” at the end of the paragraph and adding in its place a “.”.

C. Revising paragraph (d)(1)(iii).

D. Redesignating paragraph (d)(1)(vi) as (d)(1)(x).

D. Adding new paragraphs (d)(1)(vi) through (d)(1)(ix).

E. Revising the introductory text of newly redesignated paragraph (d)(1)(x).

F. Revising the introductory text of paragraph (d)(2).

G. Adding paragraph (f).

The revisions and additions read as follows:

§ 431.980 Eligibility review procedures.

* * * * *

(d) * * *

(1) *Active cases—Medicaid*. Unless the State has selected to substitute MEQC data for PERM data under paragraph (f) of this section, the agency must complete all of the following:

* * * * *

(iii) Examine the evidence in the case file that supports categorical and financial eligibility for the category of coverage in which the case is assigned, and independently verify information that is missing, older than 12 months and likely to change, or otherwise as needed, to verify eligibility.

* * * * *

(vi) Elements of eligibility in which State policy allows for self-declaration can be verified with a new self-declaration statement.

(vii) The self-declaration must be—

(A) Present in the record;

(B) Not outdated (more than 12 months old);

(C) In a valid, State-approved format; and

(D) Consistent with other facts in the case record.

(viii) If a self-declaration statement in the case record is more than 12 months old, eligibility may be verified through a new self-declaration statement or other third party sources.

(ix) If eligibility or ineligibility cannot be verified, cite a case as undetermined as specified in paragraph (d)(1)(x)(B) or (d)(2)(ii) of this section.

(x) As a result of paragraphs (d)(1)(i) through (d)(1)(ix) of this section—

* * * * *

(2) *Active cases—CHIP*. In addition to the procedures for active cases as set forth in paragraphs (d)(1)(i) through (d)(1)(ix) of this section, once the agency

establishes CHIP eligibility, the agency must verify that the case is not eligible for Medicaid by determining that the child has income above the Medicaid levels in accordance with the requirements in § 457.350 of this chapter. Upon verification, the agency must—

* * * * *

(f) *Substitution of MEQC data*. (1) A State in their PERM year may elect to substitute the random sample of selected cases, eligibility review findings, and payment reviews findings obtained through MEQC reviews conducted in accordance with section 1903(u) of the Act for data required in this section, as long as the State MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the State, if the only exclusions are those set forth in section 1902(e)(13) of the Act, § 431.814(c)(4), and § 431.978(d)(1) of this part.

(2) MEQC samples must also meet PERM confidence and precision requirements.

15. Section 431.988 is amended by revising paragraphs (b)(1) and (2) to read as follows:

§ 431.988 Eligibility case review completion deadlines and submittal of reports.

* * * * *

(b) * * *

(1) Case and payment error data for active cases.

(2) Case error data for negative cases.

* * * * *

16. Section 431.992 is revised to read as follows:

§ 431.992 Corrective action plan.

(a) The State agency must develop a corrective action plan designed to reduce improper payments in its Medicaid and CHIP programs based on its analysis of the error causes in the FFS, managed care, and eligibility components.

(b) In developing a corrective action plan, the State must take the following actions:

(1) *Data analysis*. (i) States must conduct data analysis such as reviewing clusters of errors, general error causes, characteristics, and frequency of errors that are associated with improper payments as well as error causes associated with number of errors.

(ii) Data analysis may sort the predominant payment errors and number of errors by the following:

(A) *Type*: General classification (for example, FFS, managed care, eligibility).

(B) *Element*: Specific type of classification (for example, no

documentation errors, duplicate claims, ineligible cases due to excess income).

(C) *Nature*: Cause of error (for example, providers not submitting medical records, lack of systems edits, unreported changes in income that caused ineligibility).

(iii) States must analyze active and negative case errors and causes for undetermined case findings under the eligibility component.

(2) *Program analysis*. (i) States must review the findings of the data analysis to determine the specific programmatic causes to which errors are attributed (for example, provider lack of understanding of the PERM requirement to provide documentation) and to identify root error causes.

(ii) The States may need to analyze the agency's operational policies and procedures and identify those policies or procedures, or both that are prone to contribute to errors, for example, unclear policies or lack of operational oversight at the local level.

(3) *Corrective action planning*. States must determine the corrective actions to be implemented that address the root error causes.

(4) *Implementation and monitoring*. (i) States must develop an implementation schedule for each corrective action initiative and implement those actions in accordance with the schedule.

(ii) The implementation schedule must identify the following:

- (A) Major tasks;
- (B) Key personnel responsible for each activity; and
- (C) A timeline for each action including target implementation dates, milestones, and monitoring.

(5) *Evaluation*. States must evaluate the effectiveness of the corrective action by assessing the following:

- (i) Improvements in operations;
- (ii) Efficiencies;
- (iii) Number of errors; and
- (iv) Improper payments.

(c) The State agency must submit to CMS and implement the corrective action plan for the fiscal year it was reviewed no later than 60 calendar days after the date on which the State's Medicaid or CHIP error rates are posted on the CMS contractor's Web site.

(d) The State must submit a new corrective action plan for each subsequent error rate measurement that contains an update on the status of a previous corrective action plan. Items to address in the new corrective action plan include, but are not limited to the following:

(1) Effectiveness of implemented corrective actions, as assessed using concrete data.

(2) Discontinued or ineffective actions, actions not implemented, and those actions, if any, that were substituted for such discontinued, ineffective, or abandoned actions.

(3) Findings on short-term corrective actions.

(4) The status of the long-term corrective actions.

17. Section 431.998 is amended by—

- A. Revising the section heading as set forth below.
- B. Revising paragraphs (a) and (b).
- C. Redesignating paragraph (c) as (d).
- D. Adding new paragraph (c).

The revisions and addition read as follows:

§ 431.998 Difference resolution and appeal process.

(a) The State may file, in writing, a request with the Federal contractor to resolve differences in the Federal contractor's findings based on medical or data processing reviews on FFS and managed care claims in Medicaid or CHIP within 10 business days after the disposition report of claims review findings is posted on the contractor's Web site. The State must complete all of the following:

(1) Have a factual basis for filing the difference.

(2) Provide the Federal contractor with valid evidence directly related to the error finding to support the State's position that the claim was properly paid.

(b) For a claim in which the State and the Federal contractor cannot resolve the difference in findings, the State may appeal to CMS for final resolution within 5 business days from the date of the contractor's finding as a result of the difference resolution is posted on the contractor's Web site. There is no minimum dollar threshold required to appeal a difference in findings.

(c) For eligibility error determinations made by agencies or personnel functionally and physically separate from the State agencies and personnel that are responsible for Medicaid and CHIP policy and operations, the State may appeal error determinations by filing an appeal request.

(1) *Filing an appeal request*. The State may—

- (i) File its appeal request with the appropriate State agency; or
- (ii) If no appeals process is in place at the State level, differences in findings—

(A) Must be documented in writing for the independent State agency to consider; or

(B) May be resolved at the State level through document exchange facilitated by CMS.

(2) *After the filing of an appeals request*. (i) Any changes in error findings must be reported to CMS by the deadline for submitting final eligibility review findings.

(ii) Any unresolved differences may be addressed by CMS not less than 60 days and no more than 90 days after the State submits its eligibility error data.

(iii) Any appeals of determinations based on interpretations of Federal policy may be referred to CMS.

(iv) If CMS's decision causes an erroneous payment finding to be made, any resulting recoveries are governed by § 431.1002 of this subchapter.

* * * * *

PART 447—PAYMENTS FOR SERVICES

18. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

19. In 42 CFR part 447, revise all references to "SCHIP" to read "CHIP".

20. In § 447.504 amend paragraph (g)(15) by revising the reference to "State Children's Health Insurance Program" to read "Children's Health Insurance Program."

PART 457—ALLOTMENTS AND GRANTS TO STATES

21. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

22. In 42 CFR part 457, revise all references to "SCHIP" to read "CHIP".

23. Section 457.10 is amended by—

- A. Adding the definition of "Children's Health Insurance Program" in alphabetical order.
- B. Removing the definition of "State Children's Health Insurance Program."

The addition reads as follows:

§ 457.10 Definitions and use of terms.

* * * * *

Children's Health Insurance Program (CHIP) means a program established and administered by a State, jointly funded with the Federal government, to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination program.

* * * * *

24. In 42 CFR part 457, revise all references to "State Children's Health Insurance Program" to read "Children's Health Insurance Program."

Authority: (Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program).

Dated: April 14, 2009.

Charlene Frizzera,

*Acting Administrator, Centers for Medicare
& Medicaid Services.*

Approved: May 7, 2009.

Kathleen Sebelius,

Secretary.

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