

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Parts 431 and 457****[CMS–6068–F]****RIN 0938–AS74****Medicaid/CHIP Program; Medicaid Program and Children's Health Insurance Program (CHIP); Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act****AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Final rule.

SUMMARY: This final rule updates the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs based on the changes to Medicaid and the Children's Health Insurance Program (CHIP) eligibility under the Patient Protection and Affordable Care Act. This rule also implements various other improvements to the PERM program.

DATES: These regulations are effective on August 4, 2017.

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SUPPLEMENTARY INFORMATION:**Acronyms**

AFR Agency Financial Report
 AT Account Transfer file
 CFR Code of Federal Regulations
 CHIP Children's Health Insurance Program
 CHIPRA Children's Health Insurance Program Reauthorization Act of 2009
 CMS Centers for Medicare and Medicaid Services
 DAB Departmental Appeals Board
 DHHS Department of Health and Human Services
 DP Data Processing
 ELA Express Lane Agency
 ELE Express Lane Eligibility
 EOB Explanation of Benefits
 ERC Eligibility Review Contractor
 FFE Federally Facilitated Exchange
 FFE–A Federally Facilitated Exchange–Assessment
 FFE–D Federally Facilitated Exchange–Determination
 FFP Federal Financial Participation
 FFS Fee-For-Service
 FFY Federal Fiscal Year
 FMAP Federal Medical Assistance Percentages
 FY Fiscal Year
 HHS Health and Human Services
 HIPP Health Insurance Premium Payments

IFR Interim Final Rule with comment period
 IPERA Improper Payments Elimination and Recovery Act
 IPERIA Improper Payments Elimination and Recovery Improvement Act
 IPIA Improper Payments Information Act
 IRFA Initial Regulatory Flexibility Analysis
 MAGI Modified Adjusted Gross Income
 MEQC Medicaid Eligibility Quality Control
 MSO Medicaid State Operations
 OMB Office of Management and Budget
 PCCM Primary Care Case Management
 PERM Payment Error Rate Measurement
 RC Review Contractor
 RFA Regulatory Flexibility Act
 RIA Regulatory Impact Analysis
 SC Statistical Contractor
 SHO State Health Official
 the Act Social Security Act
 UMRA Unfunded Mandates Reform Act

I. Background**A. Introduction**

The Medicaid Eligibility Quality Control (MEQC) program at § 431.810 through 431.822 implements section 1903(u) of the Social Security Act (the Act) and requires each state to report to the Secretary the ratio of its erroneous excess payments for medical assistance under its state plan to its total expenditures for medical assistance. Section 1903(u) of the Act sets a 3 percent threshold for eligibility-related improper payments in any fiscal year (FY) and generally requires the Secretary to withhold payments to states with respect to the amount of improper payments that exceed that threshold.

The Payment Error Rate Measurement (PERM) program was developed to implement the requirements of the Improper Payments Information Act (IPIA) of 2002 (Pub. L. 107–300, enacted January 23, 2002), which requires the heads of federal agencies to review all programs and activities that they administer to determine if any programs are susceptible to significant erroneous payments, and, if so, to identify them. IPIA was amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) (Pub. L. 111–204, enacted on July 22, 2010) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) (Pub. L. 112–248, enacted on January 10, 2013).

The IPIA directed the Office of Management and Budget (OMB) to provide guidance on implementation; OMB provides such guidance for IPIA, IPERA, and IPERIA in OMB circular A–123 App. C. OMB defines “significant improper payments” as annual erroneous payments in the program exceeding (1) both \$10 million and 1.5

percent of program payments, or (2) \$100 million regardless of percentage (OMB M–15–02, OMB Circular A–123, App. C October 20, 2014). Erroneous payments and improper payments have the same meaning under OMB guidance.

For those programs found to be susceptible to significant erroneous payments, federal agencies must provide the estimated amount of improper payments and report on what actions the agency is taking to reduce those improper payments, including setting targets for future erroneous payment levels and a timeline by which the targets will be reached. Section 2(b)(1) of IPERA clarified that, when meeting IPIA and IPERA requirements, agencies must produce a statistically valid estimate, or an estimate that is otherwise appropriate using a methodology approved by the Director of OMB. IPERIA further clarified requirements for agency reporting on actions to reduce and recover improper payments.

The Medicaid program and the Children's Health Insurance Program (CHIP) were identified as at risk for significant erroneous payments by OMB. As set forth in OMB Circular A–136, Financial Reporting Requirements, for IPIA reporting, the Department of Health and Human Services (DHHS) reports the estimated improper payment rates (and other required information) for both programs in its annual Agency Financial Report (AFR).

Sections 203 and 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111–3, enacted on February 4, 2009) relate to the PERM program. Section 203 of the CHIPRA amended sections 1902(e)(13) and 2107(e)(1) of the Act to establish a state option for an express lane eligibility (ELE) process for determining eligibility for children and an error rate measurement for the enrollment of children under the ELE option. ELE provides states with important new avenues to expeditiously facilitate children's Medicaid or CHIP enrollment through a fast and simplified eligibility determination or renewal process by which states may rely on findings made by another program designated as an express lane agency (ELA) for eligibility factors including, but not limited to, income or household size. Section 1902(e)(13)(E) of the Act, as amended by the CHIPRA, specifically addresses error rates for ELE. States are required to conduct a separate analysis of ELE error rates, applying a 3 percent error rate threshold, and are directed not to include those children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on

a finding made by an ELA in any data or samples used for purposes of complying with a MEQC review or as part of the PERM measurement. Section 203(b) of the CHIPRA directed the Secretary to conduct an independent evaluation of children who enrolled in Medicaid or CHIP plans through the ELE option to determine the percentage of children who were erroneously enrolled in such plans, the effectiveness of the option, and possible legislative or administrative recommendations to more effectively enroll children through reliance on such findings.

Section 601(a)(1) of the CHIPRA amended section 2015(c) of the Act, and provided a 90 percent federal match for CHIP spending related to PERM administration and excluded such spending from the CHIP 10 percent administrative cap. (Section 2105(c)(2) of the Act generally limits states to using no more than 10 percent of the CHIP benefit expenditures for administrative costs, outreach efforts, additional services other than the standard benefit package for low-income children, and administrative costs.)

Section 601(b) of the CHIPRA required that the Secretary issue a new PERM rule and delay any calculations of a PERM improper payment rate for CHIP until 6 months after the new PERM final rule was effective. Section 601(c) of the CHIPRA established certain standards for such a rule, and section 601(d) of the CHIPRA provided that states that were scheduled for PERM measurement in FY 2007 or 2008, respectively, could elect to accept a CHIP PERM improper payment rate determined in whole or in part on the basis of data for FY 2007 or 2008, respectively, or could elect instead to consider its PERM measurement conducted for FY 2010 or 2011, respectively, as the first fiscal year for which PERM applied to the state for CHIP. The new PERM rule required by the CHIPRA was to 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 (CAPs).
- 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.

The Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education

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

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

In light of the implementation of the Affordable Care Act's major changes to the Medicaid and CHIP eligibility and enrollment provisions, and our continued efforts to comply with IPERIA and the CHIPRA, an interim change in methodology was implemented for conducting Medicaid and CHIP eligibility reviews under PERM. As described in an August 15, 2013 State Health Official (SHO) letter (SHO #13–005), instead of the PERM and MEQC eligibility review requirements, we required states to participate in Medicaid and CHIP Eligibility Review Pilots from FY 2014 to FY 2016 to support the development of a revised PERM methodology that provides informative, actionable information to states and allows CMS to monitor program administration. A subsequent SHO letter dated October 7, 2015 (SHO #15–004) extended the Medicaid and CHIP Eligibility Review Pilots for one additional year.

B. Regulatory History

1. Medicaid Eligibility Quality Control (MEQC) Program

The MEQC program implements section 1903(u) of the Act, which defines erroneous excess payments as both payments for ineligible persons and overpayments for eligible persons. Section 1903(u) of the Act instructs the Secretary not to make payment to a state with respect to the portion of its erroneous payments that exceed a 3 percent error rate, though the statute also permits the Secretary to waive all or part of that payment restriction if a state demonstrates that it cannot reach the 3 percent allowable error rate despite a good faith effort.

Regulations implementing the MEQC program are at 42 CFR part 431, subpart P—Quality Control. The regulations specify the sample and review procedures for the MEQC program and standards for good faith efforts to keep improper payments below the error rate threshold. From its implementation in 1978 until 1994, states were required to follow the as-promulgated MEQC regulations in what was known as the traditional MEQC program. Every month, states reviewed a random sample of Medicaid cases and verified the categorical and financial eligibility of the case members. Sample sizes had to meet minimum standards, but otherwise were at state option.

For cases in the sample found ineligible, the claims for services received in the review month were collected, and error rates were calculated by comparing the amount of such claims to the total claims for the universe of sampled claims. The state's calculated error rate was adjusted based on a federal validation subsample to arrive at a final state error rate. This final state error rate was calculated as a point estimate, without adjustment for the confidence interval resulting from the sampling methodology. States with error rates over 3 percent were subject under those regulations to a disallowance of FFP in all or part of the amount of FFP over the 3 percent error rate.

At HHS's Departmental Appeals Board (DAB), HHS's final level of administrative review, states prevailed in challenges to disallowances based on the MEQC system in 1992. The DAB concluded that the MEQC sampling protocol and the resulting error rate calculation were not sufficiently accurate to provide reliable evidence to support a disallowance based on an actual error rate exceeding the 3 percent threshold.

Although the MEQC system remained in place, we provided states with an alternative to the MEQC program that was focused on prospective improvements in eligibility determinations rather than disallowances. These changes, outlined in Medicaid State Operations (MSO) Letter #93-58, dated July 23, 1993, provided states with the option to continue operating a traditional MEQC program, or to conduct what we termed "MEQC pilots," that did not lead to the calculation of error rates (or, therefore, to disallowances). These pilots continue today. States choosing the latter pilot option have generally operated, on a year-over-year basis, year-long pilots focused on state-specific areas of interest, such as high-cost or high-risk eligibility categories and problematic eligibility determination processes. These pilots review specific program areas to determine whether problems exist and produce findings the state agency can address through corrective actions, such as policy changes or additional training. Over time, most states have elected to participate in the pilots; 39 states now operate MEQC pilots, while 12 maintain traditional MEQC programs.

2. Payment Error Rate Measurement (PERM) Program

We issued the August 27, 2004 proposed rule (69 FR 52620) as a result of the IPIA and OMB guidance that set forth proposed provisions establishing the PERM program by which states would annually be required to estimate and report improper payments in the Medicaid program and CHIP. The state-reported, state-specific, improper payment rates were to be used to compute the national improper payment estimates for these programs.

In the October 5, 2005 **Federal Register** (70 FR 58260), we published a PERM interim final rule (IFR) with comment period that responded to public comments on the proposed rule and informed the public of both our national contracting strategy and plan to measure improper payments in a subset of states. That IFR with comment period described that a state's Medicaid program and CHIP would be subject to PERM measurement just once every 3 years; the 3 year period is referred to as a cycle, and the year in which a state is measured is known as its "PERM year." In response to the public comments from that IFR, we published a second IFR with comment period in the August 28, 2006 **Federal Register** (71 FR 51050) that reiterated our national contracting strategy to estimate improper payments in both Medicaid and CHIP fee-for-

service (FFS) and managed care. We set forth, and invited comments on, state requirements for estimating improper payments due to Medicaid and CHIP eligibility determination errors. We also announced that a state's Medicaid program and CHIP would be reviewed during the same cycle.

In the August 31, 2007 **Federal Register** (72 FR 50490), we published a PERM final rule that finalized state requirements for: (1) Submitting claims to the federal contractors that conduct FFS and managed care reviews; (2) conducting eligibility reviews; and (3) estimating payment error rates due to errors in eligibility determinations.

3. 2010 Final Rule: Revisions to MEQC and PERM To Meet the CHIPRA Requirements

In the July 15, 2009 **Federal Register** (74 FR 34468), we published a proposed rule which proposed revisions, as required by the CHIPRA, to the MEQC and PERM programs, including changes to the PERM review process.

In the August 11, 2010 **Federal Register** (75 FR 48816), we published a final rule for the MEQC and PERM programs, which became effective on September 10, 2010, that codified several procedural aspects of the process for estimating improper payments in Medicaid and CHIP, including: Changes to state-specific sample sizes to reduce state burden; the stratification of universes to obtain required precision levels; eligibility sampling requirements; the modification of review requirements for self-declaration or self-certification of eligibility; the exclusion of children enrolled through the ELE from the PERM measurement; clearly defined "types of payment errors" to clarify that errors must affect payments for the purpose of the PERM program; a clearly defined difference resolution and appeals process; and state requirements for implementation of CAPs.

Section 601(e) of the CHIPRA required harmonizing the MEQC and PERM programs' eligibility review requirements to improve coordination of the two programs, decrease duplicate efforts, and minimize state burden. To comply with the CHIPRA, the final rule granted states the flexibility, in their PERM year, to apply PERM data to satisfy the annual MEQC requirements, or to apply "traditional" MEQC data to satisfy the PERM eligibility component requirements.

The August 11, 2010 final rule permitted a state to use the same data, such as the same sample, eligibility review findings, and payment review findings, for each program. However,

the CHIPRA permits substituting PERM and MEQC data only where the MEQC review is conducted under section 1903(u) of the Act, so only states using the "traditional" MEQC methodology may employ this substitution option. Also, each state, with respect to each program (MEQC and PERM) is still required to develop separate error/improper payment rate calculations.

II. Provisions of the Proposed Rule and Analysis of and Responses to Comments

We received 20 timely comments from the public, in response to the proposed rule published on June 22, 2016 (81 FR 40596). The following sections, arranged by subject area, include a summary of the public comments received and our responses.

We received comments from the public, State Medicaid agencies, advocacy groups, a non-partisan legislative branch agency, and associations. The comments ranged from general support or opposition to the proposed provisions to very specific questions or comments regarding the proposed changes.

Many commenters raised issues centered around the PERM managed care component and the transparency and public reporting aspects of both the PERM and MEQC programs. We believe that these issues are beyond the scope of this final rule. However, we may consider whether to take other actions, such as revising or clarifying CMS program operating instructions or procedures, based on the information or recommendations in the comments. Brief summaries of each proposed provision, a summary of the public comments we received (with the exception of specific comments on the paperwork burden or the economic impact analysis), and our responses to the comments are provided in this final rule. Comments related to the paperwork burden and the impact analyses included in the proposed rule are addressed in the "Collection of Information Requirements" and "Regulatory Impact Statement" sections in this final rule. The final regulation text follows these analyses.

We proposed the following changes to part 431 to address the eligibility provisions of the Affordable Care Act, as well as to make improvements to the PERM and MEQC programs.

A. MEQC Program Revision

Section 1903(u) of the Act requires the review of Medicaid eligibility to identify erroneous payments, but it does not specify the manner by which such reviews must occur. The MEQC program

was originally created to implement the requirements of section 1903(u) of the Act, but the PERM program, implemented subsequent to MEQC and under other legal authority, likewise reviews Medicaid eligibility to identify erroneous payments. As noted previously, the CHIPRA required harmonizing the MEQC and PERM programs and allowed for certain data substitution options between the two programs, to coordinate consistent state implementation to meet both sets of requirements and reduce redundancies. Because states are subject to PERM reviews only once every 3 years, we proposed to meet the requirements in section 1903(u) of the Act through a combination of the PERM program and a revised MEQC program that resembles the current MEQC pilots, by which the revised MEQC program would provide measures of a state's erroneous eligibility determinations in the 2 off-years between its PERM years.

As previously noted, states currently may satisfy our requirements by conducting either a traditional MEQC program or MEQC pilots, with the majority of states (39) electing the latter due to the pilots' flexibility to target specific problematic or high-interest areas. The revised MEQC program will eliminate the traditional MEQC program and, instead, formalize, and make mandatory, the pilot approach. During the 2 off-years between each state's PERM years, when a state is not reviewed under the PERM program, we proposed that it conduct one MEQC pilot spanning that 2-year period. The revised regulations will conform the MEQC program to how the majority of states have applied the MEQC pilots through the administrative flexibility we granted states decades ago to meet the requirements of section 1903(u) of the Act. We believe such MEQC pilots will provide states with the necessary flexibility to target specific problems or high-interest areas as necessary. As a matter of semantics, note that in the proposed rule we continued to use the term "pilots," not because they are fixed or defined projects (as the term sometimes connotes), but, rather because, as described, states will have flexibility to adapt pilots to target particular areas.

We further proposed to take a similar approach to "freezing" error rates as we took when we initially introduced MEQC pilots 2 decades ago. In 1994, when we introduced MEQC pilots we offered states the ability to "freeze" their error rates until they resumed traditional MEQC activities. Similarly, we proposed to freeze a state's most recent PERM eligibility improper

payment rate during the 2 off-years between a state's PERM cycles, when the state will be conducting an MEQC pilot. As noted previously, section 1903(u) of the Act sets a 3 percent threshold for improper payments in any period or fiscal year and generally requires the Secretary to withhold payments to states with respect to the amount of improper payments that exceed the threshold. Therefore, we proposed freezing the PERM eligibility improper payment rate as it allows each state a chance to test the efficacy of its corrective actions as related to the eligibility errors identified during its PERM year. Our provisions also allow states a chance to implement prospective improvements in eligibility determinations before having their next PERM eligibility improper payment measurement performed, where identified improper payments will be subject to potential payment reductions and disallowances under 1903(u) of the Act.

We proposed to revise § 431.800 to revise and clarify the MEQC program basis and scope.

Comment: Several commenters supported our proposal to revise the MEQC program into a pilot program that works in conjunction with the PERM program.

Response: We appreciate the commenters' support, and we are finalizing as proposed.

We proposed to remove § 431.802 as FFP, state plan requirements, and the requirement for the MEQC program to meet section 1903(u) of the Act will no longer be applicable to the revised MEQC program.

We did not receive any comments on this proposal, and therefore, we are finalizing as proposed.

We proposed to revise § 431.804 by adding definitions for "corrective action," "deficiency," "eligibility," "Medicaid Eligibility Quality Control (MEQC)," "MEQC Pilot," "MEQC review period," "negative case," "off years," "Payment Error Rate Measurement (PERM)," and "PERM year."

We proposed to revise the definitions for "active case," and "eligibility error," and remove "administrative period," "claims processing error," "negative case action," and "state agency." We proposed to add, revise, or remove definitions to provide additional clarification for the proposed MEQC program revisions.

The following is summary of the comments we received regarding our proposal to add, revise, or remove definitions.

Comment: One commenter stated that the MEQC definition of "deficiency" should not include the word "error" in it since "eligibility error" is separately defined.

Response: As stated in this final rule, the revised MEQC definition of "deficiency" means a finding that does not meet the definition of an "eligibility error." Therefore, we believe it is appropriate to also separately define the term "eligibility error." However, we acknowledge that we made a technical error in that the proposed PERM definition of "deficiency" was inadvertently published as the MEQC definition of "deficiency," which likely contributed to reader confusion and the request for clarification. As such, we finalize the MEQC definition for "deficiency" to read that deficiency means a finding in processing identified through active case review or negative case review that does not meet the definition of an eligibility error.

Comment: Multiple commenters requested clarification of the definition "eligibility error." More specifically, one commenter questioned whether "type of assistance" referred to "full service versus emergency service, MAGI versus Non-MAGI, Adult versus Parent Caretaker or Child or to a subgroup under one of these." Other commenters requested clarification for when a redetermination would not be considered timely in relationship to previous determinations, and claim payments. And some commenters requested clarification surrounding the meaning of the phrase "a required element of the eligibility determination process cannot be verified as being performed/completed by the state."

Response: In this context, "type of assistance" refers to the specific eligibility categories within Medicaid or CHIP, such as parents and caretakers, children, pregnant women, and adult expansion group, within which different benefits may be provided. States may use different terminology to refer to eligibility categories, including type of assistance. Next, federal regulations found at 42 CFR part 435 subpart J clearly define timely redeterminations. Lastly, documentation and record keeping requirements relevant to state determinations of eligibility are outlined in federal regulations, and, therefore, states should be maintaining information required for review. Federal eligibility regulations are very specific for certain elements of eligibility (such as, but not limited to, citizenship and immigration status) as to what the state must do to have successfully verified an individual's eligibility for medical assistance. Thus, if the state is unable to

provide the necessary documentation to support the state's eligibility determination, the payment under review may be cited as an error due to insufficient documentation. We are finalizing the definition of "eligibility error" as proposed.

Comment: Many commenters made recommendations on policies that should be included in the MEQC review instructions that will be provided by CMS following publication of the final rule.

Response: While we appreciate these recommendations, they are beyond the scope of the proposed changes of the rule. We may consider these recommendations when developing CMS guidance. The MEQC pilot program review procedures are outlined at § 431.812; states will be required to follow the review procedures as outlined there, in addition to other instructions established by CMS.

Comment: One commenter requested that CMS not remove the definition "administrative period," stating that the current regulation excludes the additional errors discovered for a period of time following the discovery of the initial and/or original error, and that the "administrative period" recognizes Medicaid policy that requires states to provide notice to beneficiaries prior to discontinuing benefits. Further, the commenter stated that erroneous benefits issued between the time in which the error is discovered and the dates in which the change in benefit level can be applied are unavoidable.

Response: We removed the "administrative period" definition because the terminology is not applicable to the proposed changes to the MEQC program, and, therefore, no longer used in the regulation text. Thus, the definition will not be included in the regulation text.

As a result of the comments, and in light of the acknowledged technical error, the definition for "deficiency" has been replaced at § 431.804 with the appropriate MEQC definition. Additionally, we made minor stylistic changes to the definitions of "PERM" and "PERM year." We received many comments supporting the changes to the MEQC program, which includes the definitions, and are finalizing all other added, revised, or removed definitions as proposed.

We proposed to revise § 431.806 to reflect the state requirements for the MEQC pilot program. Section 431.806 clarifies that following the end of a state's PERM year, it would have up to November 1 to submit its MEQC pilot planning document for our review and approval. We did not receive any

comments on this proposal, and therefore, we are finalizing as proposed.

We proposed to revise § 431.810 to clarify the basic elements and requirements of the MEQC program. We did not receive any comments on this proposal, and therefore, we are finalizing as proposed.

We proposed to revise § 431.812 to clarify the review procedures for the MEQC program. As described previously, the CHIPRA required harmonizing the PERM and MEQC programs and authorized us to permit states to use PERM to fulfill the requirements of section 1903(u) of the Act; § 431.812(f), which permits states to substitute PERM-generated eligibility data to meet MEQC program requirements, was issued under the CHIPRA authority. Given that the Congress, in the CHIPRA, directed the Secretary to harmonize the PERM and MEQC programs and expressly permitted states to substitute PERM for MEQC data, we believe that the PERM program, with the proposed revisions discussed in subpart Q, meets the requirements of section 1903(u) of the Act.

Our approach will continue to harmonize the PERM and MEQC programs. It will reduce the redundancies associated with meeting the requirements of two distinct programs. As noted, the CHIPRA, with certain limitations, allows for substitution of MEQC data for PERM eligibility data. Through our approach, in their PERM year, states will participate in the PERM program, while during the 2 off-years between a state's PERM cycles they would conduct a MEQC pilot, markedly reducing states' burden. Moreover, we proposed to revise the methodology for PERM eligibility reviews, as discussed in sections §§ 431.960 through 431.1010. The MEQC pilots will focus on areas not addressed through PERM reviews, such as negative cases and understated/overstated liability, as well as permit states to conduct focused reviews on areas identified as error-prone through the PERM program, so the new cyclical PERM/MEQC rotation will yield a complementary approach to ensuring accurate eligibility determinations.

By conducting eligibility reviews of a sample of individuals who have received services matched with Title XIX or XXI funds, the PERM program will continue to focus on identifying individuals receiving medical assistance under the Medicaid or CHIP programs who are, in fact, ineligible. Such PERM eligibility reviews conform to the requirement at section 1903(u) of the Act's that states measure erroneous

payments due to ineligibility. Likewise, these eligibility reviews will continue under the MEQC pilots during states' off-years and include a review of Medicaid spend-down as a condition of eligibility, conforming to other state measurement requirements of section 1903(u) of the Act. We will calculate a state's eligibility improper payment rate during its PERM year, which will remain frozen at that level during its 2 off-years when it conducts its MEQC pilot. Again, freezing states' eligibility improper payment rates between PERM cycles will allow states time to work on effective and efficacious corrective actions that would improve their eligibility determinations. This approach also encourages states to pursue prospective improvements to their eligibility determination systems, policies, and procedures before their next PERM cycle, in which an eligibility improper payment rate will be calculated with the potential for payment reductions and disallowances to be invoked, in the event that a state's eligibility improper payment rate is above the 3 percent threshold.

1. Revised MEQC Review Procedures

For more than 2 decades, the majority of states have used the flexibility of MEQC pilots to review state-specific areas of interest, such as high-cost or high-risk eligibility categories and problematic eligibility determination processes. This flexibility has been beneficial to states because it made MEQC more useful from a corrective action standpoint.

We proposed that MEQC pilots focus on cases that may not be fully addressed through the PERM review, including, but not limited to, negative cases and payment reviews of understated and overstated liability. Still, states will retain much of their current flexibility. In § 431.812, we proposed that states must use the MEQC pilots to perform both active and negative case reviews, but states would have flexibility surrounding their active case review pilot. In the event that a state's eligibility improper payment rate is above the 3 percent threshold for two consecutive PERM cycles, this flexibility will decrease as states will be required to comply with CMS guidance to tailor the active case reviews to a more appropriate MEQC pilot that would be based upon a state's PERM eligibility findings. To ensure that states with consecutive PERM eligibility improper payment rates over the threshold identify and conduct MEQC active case reviews that are appropriate during their off-years, we will provide direction for conducting a MEQC pilot

that would suitably address the error-prone areas identified through the state's PERM review. Both the PERM and MEQC pilot programs are operationally complementary, and should be treated in a manner that allows for states to review identified issues, develop corrective actions, and effectively implement prospective improvements to their eligibility determinations.

Active and negative cases represent the eligibility determinations made for individuals that either approve or deny an individual's eligibility to receive benefits and/or services under Medicaid or CHIP. Individuals who are found to be eligible and authorized to receive benefits/services are termed active cases, whereas individuals who are found to be ineligible for benefits are known as negative cases. As finalized at § 431.812(b)(3), a state must focus its active case reviews on three defined areas, unless otherwise directed by CMS, or, as finalized at § 431.812(b)(3)(i), it may perform a comprehensive review that does not limit its review of active cases. Additionally, we proposed that the MEQC pilots must include negative cases because we also proposed to eliminate PERM's negative case reviews; our proposal would ensure continuing oversight over negative cases to ensure the accuracy of state determinations to deny or terminate eligibility.

Under the new MEQC pilot program, we proposed that states review a minimum total of 400 Medicaid and CHIP active cases. We proposed that at least 200 of those reviews must be

Medicaid cases and expect that states will include some CHIP cases, but beyond that, we proposed that states would have the flexibility to determine the precise distribution of active cases. For example, a state could sample 300 Medicaid and 100 CHIP active cases; it would describe its active sample distribution in its MEQC pilot planning document that it would submit to us for approval. Under the new MEQC pilot program, we also proposed that states review, at a minimum, 200 Medicaid and 200 CHIP negative cases. Currently, under the PERM program, states are required to conduct approximately 200 negative case reviews for both the Medicaid program and CHIP (204 is the base sample size, which may be adjusted up or down from cycle to cycle depending on a state's performance). We proposed a minimum total negative sample size of 400 (200 for each program) for the proposed MEQC pilots because, as mentioned above and discussed further below, we proposed to eliminate PERM's negative case reviews.

Historically, MEQC's case reviews (both active and negative) focused solely on Medicaid eligibility determinations. The new MEQC pilots will now include both Medicaid and CHIP eligibility case reviews. Because we proposed to eliminate PERM's negative case reviews, it is important that we concomitantly expand the MEQC pilots to include the review of no less than 200 CHIP negative cases to ensure that CHIP applicants are not inappropriately denied or terminated from a state's program. In the event that CHIP funding should end, then states would be

required to review only Medicaid active and negative cases, as there would no longer be any cases associated with CHIP funding.

We will provide states with guidelines for conducting these MEQC pilots, and states must submit MEQC pilot planning documents for CMS's approval. This approach will ensure that states are planning to conduct pilots that are suitable and in accordance with our guidance.

This final rule will require states to conduct one MEQC pilot during their 2 off-years between PERM cycles. We proposed that the MEQC pilot review period span 12 months, beginning on January 1, following the end of the state's PERM review period. For instance, if a state's PERM review period is July 1, 2018 to June 30, 2019, the next proposed MEQC pilot review period would be January 1 to December 31, 2020. We proposed at § 431.806 that a state would have up to November 1 following the end of its PERM review period to submit its MEQC pilot planning document for CMS review and approval. Following a state's MEQC pilot review period, we proposed it would have up to August 1 to submit a CAP based on its MEQC pilot findings.

We realize that on the effective date of this final rule, states will not all be at the same point in the MEQC pilot program/PERM timeline. The impact of the proposed MEQC timeline for each cycle of states is clarified below to assist each cycle of states in understanding when the proposed MEQC requirements would apply.

Cycle 1 states	Cycle 2 states	Cycle 3 states
First PERM review period: July 2017–June 2018. First MEQC pilot planning document due: November 1, 2018. MEQC review period: January 1–December 31, 2019. MEQC findings and CAP due: August 1, 2020.	CMS will provide guidance regarding a modified MEQC pilot that will occur prior to the beginning of your first PERM cycle. First PERM review period: July 2018–June 2019.	First MEQC pilot planning document due: November 1, 2017. MEQC review period: January 1–December 31, 2018. MEQC findings and CAP due: August 1, 2019. First PERM review period: July 2019–June 2020.

The following is a summary of the comments we received regarding our proposal to revise the review procedures for the MEQC program.

Comment: A commenter requested that the personnel responsible for the MEQC activities not be required to be functionally and physically separate from the personnel responsible for Medicaid and CHIP policy and operations since there is no longer a disallowance under MEQC.

Response: We appreciate the commenter's suggestion, but we decline

to change this requirement. We believe this separation is important to ensure accurate and unbiased review and reporting by states in order to maintain important oversight of eligibility determinations and to lower PERM improper payment rates.

Comment: A commenter requested clarification surrounding the MEQC negative case reviews, stating since each CHIP decision includes a Medicaid determination, the same case should be used to fulfill the requirement for both

Medicaid and CHIP reviews of 200 negative cases.

Response: The regulation does not prevent the same case from being in both the Medicaid and CHIP negative case samples if applicable. States must submit a pilot planning document that meets the requirements of § 431.814 for both the active and negative case reviews, which is subject to CMS approval. However, we will not approve a negative case review pilot planning document for any state that chooses to only review cases that were denied

coverage by both Medicaid and CHIP, or a proposal that does not meet CMS requirements.

Comment: Several commenters requested that CMS include more details surrounding the MEQC pilot review procedures in the regulatory text of the final rule, including what will be in the future CMS subregulatory guidance.

Response: Forthcoming MEQC program operating instructions and procedures will provide further detail on review and reporting requirements. The regulatory text outlines the general framework for the pilot program and the forthcoming guidance will contain specific implementing and operating guidelines.

Comment: One commenter disagreed with the proposed new MEQC review schedule of 1 year on, and 2 years off. The commenter requested that CMS consider changing the proposed MEQC review schedule to an ongoing annual review cycle.

Response: We appreciate the commenter's suggestion, but decline to change the proposed MEQC review schedule. Our proposed review schedule for MEQC was created to provide necessary oversight of eligibility determinations between a state's PERM cycles, account for those areas that are not fully reviewed by PERM (for example, negative cases, and overstated and understated liability), and allow states a chance to implement prospective improvements in eligibility determinations before having their next PERM eligibility improper payment measurement performed. While we are not requiring an annual review cycle, nothing in this final rule or in the regulations in this subpart should be construed as limiting the state's program integrity measures, or affecting the state's obligation to ensure that only eligible individuals receive benefits or to provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the plan.

Comment: Several commenters requested that CMS strengthen the rules for the MEQC and PERM programs to include more specific requirements for states to examine how the verification rules and eligibility processes states have put in place affect the overall customer experience and timeliness of the eligibility decision.

Response: The evaluation of customer experience is not the role of the PERM or MEQC programs. However, if there are specific concerns around a state's processes, the MEQC pilots are flexible enough that the states will, if they

choose, be able to include them as a part of their review and report on these items, in addition to improper payment information.

Comment: Several commenters requested that CMS expand the scope of the MEQC pilots to examine state processes for transferring cases to and from the exchange. Further, the commenter recommended that CMS needs to monitor account transfers to ensure that states are using the information applicants provide to the exchange and not asking for information or documentation that has already been provided, and that states are appropriately transferring denied Medicaid cases that originate with the state Medicaid agency to the exchanges.

Response: Appropriate use of applicant-provided information and transfer of denied Medicaid cases are currently a part of our eligibility review pilots, and we anticipate including instructions on review of these items in subregulatory guidance. Section 431.812 (b)(1) and (c)(1) will cover these type of process related issues as it requires states to identify deficiencies in processing subject to corrective actions.

Comment: A commenter requested that CMS direct all negative case reviews rather than leaving them to state discretion.

Response: We did propose to direct all negative case reviews and did not propose to leave them to state discretion. Negative case reviews are not given the same flexibility to focus on specific areas, like active case reviews. Additionally, all MEQC pilots, including both active and negative case reviews, require our approval. States must comply with § 431.812(a), which requires each state to conduct a MEQC pilot in accordance with the approved pilot planning document, as well as other instructions established by CMS.

Comment: A few commenters recommended that CMS direct the MEQC active case reviews immediately after a state's eligibility improper payment rate exceeds the 3 percent threshold. These commenters contend that waiting to impose this provision until a state has exceeded the 3 percent threshold in consecutive PERM cycles is too long.

Response: While we appreciate the commenter's recommendation, we are not accepting this recommendation at this time. We want to give states an opportunity to evaluate and appropriately address their PERM findings through their MEQC pilots before taking away the flexibility of a state's active case reviews. We will direct the focus of the active case reviews for those states that exceed the

3 percent in consecutive PERM cycles. However, we will continue to maintain oversight of states' reviews, and all states will need to follow CMS-provided guidance when conducting their MEQC pilot reviews. Both the PERM and MEQC pilot programs are operationally complementary, and should be treated in a manner that allows for states to review identified issues, develop corrective actions, and effectively implement prospective improvements to their eligibility determinations. This approach also encourages states to pursue prospective improvements to their eligibility determination systems, policies, and procedures before their next PERM cycle, in which an eligibility improper payment rate will be calculated with the potential for payment reductions and disallowances.

Comment: A commenter stated that § 431.812 should specify how to report payment findings and that the reference to § 431.814 does not include this information.

Response: Section 431.816 specifies requirements for case review completion and submission of reports that include the reporting of payment findings. As noted at § 431.816(b), states must submit a detailed case-level report in a format provided by CMS, and all case-level findings are due by August 1 following the end of the MEQC review period.

Comment: One commenter stated that the timing of the modified MEQC pilot program guidance will be critical for Cycle 2 states to have sufficient time to complete the pilot and implement corrective actions prior to the date of the eligibility determinations for the PERM review period beginning in 2018.

Response: We plan to issue necessary guidance upon publication of this final rule, and we believe Cycle 2 states will have sufficient time to meet the requirements of this final rule.

As a result of the comments, we do not have any revisions to the regulatory text, and, therefore, we are finalizing it as proposed.

2. MEQC Pilot Planning Document

We proposed to revise § 431.814 to clarify the revised sampling plan and procedures for the MEQC pilot program. We proposed that each state be required to submit, for our approval, a MEQC Pilot Planning Document that details how the state will perform its active and negative case reviews. This process is consistent with that used historically with MEQC pilots and also with the FY 2014 to FY 2017 Medicaid and CHIP Eligibility Review Pilots. Prior to the first submission cycle, we will provide states with guidance containing further

details informing them of what information will need to be included in the MEQC Pilot Planning Document.

The following is summary of the comments we received regarding our proposal to require states to submit a pilot planning document by November 1 following the end of the State's PERM year for each MEQC pilot that meets the requirements of § 431.814 and is subject to our approval.

Comment: Several commenters requested that CMS strengthen the pilot planning document provision to require states to include justification for the focus of the active case review, which should be based on the findings of the PERM review.

Response: We agree with this recommendation and have added the requirement to the regulatory text for states to include justification for the focus of their active case reviews. Although error prone areas would be based on each state's PERM review findings, the other options (comprehensive review, recent changes to eligibility policies and processes, or areas where the state suspects vulnerabilities) available for the active case reviews would not necessarily be tied to PERM.

Comment: One commenter stated that for the state to be timely, it is crucial that CMS have a deadline for approving a timely submitted pilot planning document because states cannot start their MEQC pilot plans without CMS approval, and recommends CMS include in the final rule a process to respond so that states can plan accordingly to meet their mandated deadlines.

Response: We intend to approve pilot planning documents as to not delay each state's MEQC pilot timeline. We cannot specify a timeline, as our approval will be dependent upon the content of each plan and the state's compliance with § 431.814.

As a result of the comments, we are revising § 431.814(1)(i) to require states to include justification for the focus of the active case reviews, and finalize the rest of § 431.814 as proposed.

3. Timeline and Reporting for MEQC Pilot Program

We proposed to revise § 431.816 to clarify the case review completion report submission deadlines. We proposed that states be required to report, through a CMS-approved Web site and in a CMS-specified format, on all sampled cases by August 1 following the end of the MEQC review period, which we believe will streamline the reporting process and ensure that all

findings are contained in a central location.

We did not receive any comments on this proposal to clarify reporting and case review submission deadlines, and therefore, we are finalizing as proposed.

We proposed to revise § 431.818 to remove the mailing requirements and the time requirement.

We did not receive any comments on this proposal to remove the mailing and time requirements from § 431.818, and therefore, we are finalizing as proposed.

4. MEQC Corrective Actions

We proposed to revise § 431.820 to clarify the corrective action requirements under the proposed MEQC pilot program. Corrective actions are critical to ensuring that states continually improve and refine their eligibility processes. Under the existing MEQC program, states must conduct corrective actions on all identified case errors, including technical deficiencies, and we proposed that states continue to be required to conduct corrective actions on all errors and deficiencies identified through the proposed MEQC pilot program.

We proposed that states report their corrective actions to CMS by August 1 following completion of the MEQC pilot review period, and that such reports also include updates on the life cycles of previous corrective actions, from implementation through evaluation of effectiveness.

The following is summary of the comments we received regarding our proposal to report on corrective actions and include updates on the life cycles of previous corrective actions.

Comment: One commenter recommended that CMS require states to include in the corrective action plan specific deadlines for addressing errors and deficiencies found in the case reviews, and for implementing corrective actions.

Response: Specific deadlines for addressing errors and deficiencies, as well as for implementing corrective actions are highly dependent on the nature of the problem and the kind and extent of the corrective action needed. States do have an incentive to act quickly, as implementing effective correction actions through MEQC allows states to pursue prospective improvements to their eligibility determination systems, policies, and procedures before their next PERM cycle, in which an eligibility improper payment rate would be calculated with the potential for payment reductions and disallowances.

Comment: One commenter recommended CMS broaden the

requirement that states provide updates on corrective actions reported for the previous MEQC pilot, to include all corrective actions, not just those reported in the MEQC pilot immediately preceding the current one that have not been addressed.

Response: We decline to accept the commenter's recommendation because such provisions would require states to report on corrective actions that may no longer be relevant. In the event that a past MEQC corrective action was not implemented by the state, similar findings would be identified during a state's PERM cycle as well as the immediately preceding MEQC pilot, and thus, would require the state to meet PERM CAP and MEQC CAP requirements.

As a result of the comments, we are finalizing this section as proposed.

We proposed to remove § 431.822, as we will no longer be performing a federal case eligibility review of the revised MEQC program.

We did not receive any comments on this proposal to remove § 431.822, and therefore, we are finalizing as proposed.

5. MEQC Disallowances

Section I.B.1 of the proposed rule, provided a detailed regulatory history of CMS's implementation of the MEQC program, and, in conformity with CMS's policy since 1993, we proposed not using the revised MEQC pilot program to reduce payments or to institute disallowances. Instead, we proposed to formalize the MEQC pilot process to align all states in one cohesive pilot approach to support and encourage states during their 2 off-years between PERM cycles to address, test, and implement corrective actions that would assist in the improvement of their eligibility determinations. This approach also better harmonizes and synchronizes the MEQC pilot and PERM programs, leaving them operationally complementary. Additionally, this provision will be advantageous to all states as they each will be exempt from potential payment reductions and disallowances while conducting their MEQC pilot; therefore placing the main focus of the pilots on the refinement and improvement of their eligibility determinations. Based on this approach, we proposed that each state's eligibility improper payment rate will be calculated in its PERM year, and that its rate will be frozen at that level during its off-years when it will conduct an MEQC pilot and implement corrective actions.

We proposed to remove § 431.865 because the CHIPRA authorized certain PERM and MEQC data substitution

allowances, upon which we believe that the PERM eligibility improper payment rate determination methodology satisfies the requirements of section 1903(u) of the Act to be used for that provision's payment reduction (and potential disallowance) requirement. Therefore, we are requiring states to use the PERM program to meet section 1903(u) of the Act requirements in their PERM years, and that potential payment reductions or disallowances only be invoked under the PERM program.

Commenters supported our proposal to remove § 431.865, and are finalizing as proposed.

6. Payment Error Rate Measurement (PERM) Program

We proposed revisions to the PERM program. Our proposed PERM eligibility component revisions have been tested and validated through multiple rounds of PERM model pilots with 15 states and through discussion with state and non-state stakeholders. The PERM model pilots were distinct from the separate FY 2014 to FY 2017 Medicaid and CHIP Eligibility Review Pilots, and were used to assess, test, and recommend changes to PERM's eligibility component review process based on the changes implemented by the Affordable Care Act. Specifically, we tested, and requested stakeholder feedback on, options in the following areas (below, there is more detail on each):

- Universe definition.
- Sample unit definition.
- Eligibility Case review approach.
- Feasibility of using a federal

contractor to conduct the eligibility case reviews.

- Difference resolution and appeals process.

Through the PERM model pilots, we have determined that each of the proposed changes support the goals of the PERM program and will produce a valid, reliable eligibility improper payment rate. We also interviewed participating states, as well as a select group of other states, to receive feedback on the majority of the proposed changes, and, to the extent possible, we addressed state concerns in the proposed rule.

7. Payment Error Rate Measurement (PERM) Measurement Review Period

Since PERM began in 2006, the measurement has been structured around the federal fiscal year (FFY) with states submitting FFS claims and managed care payments with paid dates that fall in the FFY under review. But, a data collection centered on the FFY has made it perennially challenging to finalize the improper payment rate

measurement and conduct all the related reporting to support an improper payment rate calculation by November of each year. Therefore, to provide states and CMS additional time to complete the work related to each PERM cycle prior to the annual improper payment rate publication in the AFR, to better align PERM with many state fiscal year timeframes, and to mirror the review period currently utilized in the Medicare FFS improper payment measurement program, we proposed to change the PERM review period from a FFY to a July through June period. We proposed to begin this change with the Cycle 1 states, whose PERM cycle would have started on October 1, 2017, so that Cycle 1 states would submit their 1st and 4th quarters of FFS claims and managed care payments with paid dates between, respectively, July 1 through September 30, 2017 and April 1 through June 30, 2018. Subsequent cycles would follow a similar review period.

The following is summary of the comments we received regarding our proposal to change the PERM review period.

Comment: A few commenters expressed concerns about the effective date of the new review period and when pre-cycle activities would start with the new review period. The commenters requested that CMS provide lead time to allow states sufficient time to schedule cycle kick-off activities and evaluate and prepare for the changes after the final rule is released.

Response: We will work with states as early as possible to prepare states for their next PERM cycle, regardless of the review period. We have already been working closely with states through the Medicaid and CHIP Eligibility Review Pilots over the past 3 to 4 years, while PERM eligibility reviews have been suspended. Prior to the publication of this final rule, we have worked closely with states by assisting them in evaluating their readiness for the resumption of PERM eligibility. Also, we anticipate conducting any preparation/pre-cycle work earlier than was done in previous cycles to give states advanced guidance before the cycle begins.

Comment: A commenter questioned why only the 1st and 4th quarters were mentioned, and not the 2nd and 3rd quarters for state submission of FFS and managed care payments.

Response: The 2nd and 3rd quarters will still be required. The 1st and 4th quarters are only mentioned to serve as examples to clearly display the shift in state's quarterly FFS and managed care submissions, based on the proposal to change the PERM review period. States

are still responsible for submitting 4 quarters of FFS and managed care payments within the time period finalized in this rule.

Comment: One commenter expressed concern about potential areas of overlap between cycles, which would mean that states would have less time to implement corrective actions to reduce the next cycle's improper payment rates.

Response: Although there may be some overlap for states during the initial transition between the previous and new PERM review periods, states should not wait to begin implementing corrective actions to address all identified errors and deficiencies.

Comment: One commenter questioned how the rolling national improper payment rates would be affected by the new PERM review period.

Response: There is no expected impact to the national improper payment rate. During the transition period from a federal fiscal year to the July through June review period, the assumption implied with the national rate is that the cycle rate for the July through June sampling period does not differ statistically from the previous fiscal year sampling period. We believe this assumption is reasonable given the shift in the sampling frame is only three months.

In addition to the previous comments, many commenters supported our proposal to change the PERM review period, and therefore, we are finalizing this as proposed.

We proposed to revise § 431.950 to clarify the requirement for states and providers to submit information and provide support to federal contractors to produce national improper payment estimates for Medicaid and CHIP.

We did not receive any comments specifically regarding our proposed revisions at § 431.950. However, all comments regarding our proposal to transfer the PERM eligibility review responsibility from the states to a federal contractor are listed below under the "Eligibility Federal Review Contractor and State Responsibilities" section.

We proposed various revisions to § 431.958 to add, revise, or remove definitions to provide greater clarity for the proposed PERM program changes. Proposed additions and revisions include definitions for "appeals," "corrective action," "deficiency," "difference resolution," "disallowance," "Eligibility Review Contractor (ERC)," "error," "federal contractor," "Federally facilitated exchange-determination (FFE-D)," "Federal financial participation," "finding," "Improper payment rate," "Lower limit,"

“PERM review period,” “recoveries,” “Review Contractor (RC),” “Review year,” “State-specific sample size,” “State eligibility system,” “State error,” “State payment system,” “Statistical Contractor (SC),” and removing the definitions of “active case,” “active fraud investigation,” “agency,” “case,” “case error rate,” “case record,” “last action,” “negative case,” “payment error rate,” “payment review,” “review cycle,” “sample month,” “state agency,” and “undetermined.”

The following is summary of the comments we received regarding our proposal to add, revise or remove definitions.

Comment: One commenter stated that the definition of “corrective action” was not consistent with the rest of the language surrounding corrective actions.

Response: We agree with this comment and have revised the definition of “corrective action” to be more consistent with the language surrounding corrective actions, and revised it to read as actions to be taken by the state to reduce errors or other vulnerabilities.

Comment: A commenter requested that the term “error” be removed from the definition of “deficiency,” because the term “error” is a separate definition.

Response: We agree with the commenter that defining an “error” to include only improper payments means that an error which is defined as an improper payment cannot also be a deficiency, and have changed the definition “error” to “payment error.”

Comment: One commenter requested clarification to the definition of “difference resolution,” stating that states should have the opportunity to dispute both error and deficiency findings.

Response: States currently do have the opportunity to dispute both error and deficiency findings. The proposed definition of difference resolution means a process that allows states to dispute the PERM Review Contractor and Eligibility Review Contractor “error” findings directly with the contractor. We will remove the term “error” from the definition of “difference resolution” for clarification that all findings, both errors and deficiencies, may be disputed to match the current practice.

Comment: A commenter requested that we add the term “findings” and/or “eligibility review findings” to the definition of “error.”

Response: We respectfully disagree with the commenter and find the current definition of “error” to be adequate as proposed. An error is any payment where federal and/or state

dollars were paid improperly based on PERM medical, data processing, and/or eligibility reviews.

Comment: Two commenters requested we clarify the definition of “state error.” The commenters stated that the way “state error” is currently worded seems to exclude medical review findings from the state improper payment rate.

Response: The definition of provider error, to which we made no proposed revisions, includes medical review errors at § 431.960(c). A state’s improper payment rate includes both state errors and provider errors, or, in other words, all data processing, medical review, and eligibility errors, with the exception of errors described under § 431.960(e)(2).

Comment: One commenter questioned whether or not the definition of “disallowance” applies to CHIP, stating the definition only references Medicaid.

Response: As proposed at § 457.628, regulations at §§ 431.800 through 431.1010 (related to the PERM and MEQC programs) apply to state’s CHIP programs in the same manner as they apply to state’s Medicaid programs. For clarification, we will revise the definition of “disallowance” by exchanging the term “Medical Assistance” for “Medicaid.”

Comment: Some commenters requested that CMS add a separate definition for the term “eligibility improper payment rate,” because they believe it would be disingenuous to calculate an eligibility improper payment rate which would be used in the calculation of any payment reductions and/or disallowances should a state exceed the 3 percent threshold, based on the absolute (rather than net) value of overpayments and underpayments.

Response: Although we appreciate these comments, we decline to alter the definition of the improper payment rate or to add a separate improper payment rate definition for PERM eligibility. To comply with IPERIA, “improper payment rate” is defined as an annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample. As such, eligibility improper payments are included in the “improper payment rate” definition. Further, § 431.960(d) defines an “eligibility error” as an underpayment or an overpayment. In the ‘PERM Disallowance’ section of this final rule, we address commenters concerns surrounding the inclusion of underpayments in the payment reduction/disallowance calculations.

As a result of the comments, we have revised the definition of “corrective action” to be more consistent with the rest of the regulatory language surrounding corrective actions by revising to include actions to be taken by the state to reduce errors or other vulnerabilities, removed the term “error” from the definition of “difference resolution,” revised the definition of “disallowance” by exchanging the term “Medical Assistance” for “Medicaid,” and clarified the definition of “error” is a “payment error.” We made minor stylistic changes to the definitions of “Eligibility Review Contractor (ERC),” “Federal financial participation,” “Lower limit,” “Recoveries,” “Review Contractor (RC),” “Review year,” “State eligibility system,” “State error,” and “Statistical Contractor (SC).” We are finalizing all other added, revised, or removed definitions as proposed.

We proposed to revise § 431.960 to remove references to negative case reviews and improper payments because a separate negative case review will no longer be a part of the PERM review process, as well as to provide greater clarity for the proposed PERM program changes. Note that while a separate negative case review would not be conducted as part of the proposed PERM review process, it could be possible for a negative case to be reviewed because the claims universe includes claims that have been denied. If a sampled denied claim was denied because the beneficiary was not eligible for Medicaid/CHIP benefits on the date of service, PERM would review the state’s decision to deny eligibility.

We did not receive any comments on this proposal to remove references to negative case reviews and improper payments from § 431.960, and, therefore, we are finalizing as proposed. Please note, comments received surrounding PERM’s proposal to no longer include a separate negative case review are addressed under the ‘Universe Definition’ section.

We proposed to revise § 431.972(a) to specify that states would be required to submit FFS claims and managed care payments for the new PERM Review Period.

We did not receive any comments on this proposal to require states to submit FFS claims and managed care payments, and, therefore, we are finalizing as proposed.

8. Eligibility Federal Review Contractor and State Responsibilities

Under the existing § 431.974, states conduct PERM eligibility reviews. Since the first PERM eligibility cycle in FY

2007, we have found that state resources have been burdened by having to conduct PERM eligibility reviews, and because the reviews require substantial staff resources, many states have struggled to meet review timelines. Moreover, we have found that having states conduct PERM eligibility reviews has created significant opportunity for states to misinterpret and inconsistently apply the PERM eligibility review guidance, with, for example, states having difficulty interpreting the universe definitions and case review guidelines.

To confront these challenges, we proposed to utilize a federal contractor (known as the ERC) to conduct the eligibility reviews on behalf of states. This will concomitantly reduce states' PERM program burden and ensure more consistent guidance interpretation, thereby reducing case review inconsistencies across states and improving eligibility processes related to case reviews and reporting. A federal contractor will be able to apply consistent standards and quality control processes for the reviews and improve CMS's ability to oversee the process, so improper payments will be reported consistently across states. Moreover, the ERC will allow us to gain a better national view of improper payments to better support the corrective action process and ensure accurate and timely eligibility determinations, while a third-party review team will be more consistent with standard auditing practices and our other improper payment measurement programs.

Our PERM model pilot testing has confirmed that having a federal contractor conduct eligibility reviews is feasible and improves our oversight of the process, as an experienced federal contractor can apply PERM guidance consistently across states while continuing to recognize unique state eligibility policies, processes, and systems. Further, through the pilots, we have developed processes to ensure that the federal contractor works collaboratively with state staff to ensure that the reviews are consistent with state eligibility policies and procedures.

While states will not continue to conduct PERM eligibility reviews, we envision that they will still play a role, as needed, in supporting the federal contractor. Therefore, we proposed to add state supporting role requirements by revising § 431.970 to outline data submission and state systems access requirements to support the PERM eligibility reviews and the ERC.

Under § 431.10(c)(1)(i)(A)(3), state Medicaid agencies may delegate

authority to determine eligibility for all, or a defined subset of, individuals to the Exchange, including Exchanges operated by a state or by HHS. Those states that have delegated the authority to make Medicaid/CHIP eligibility determinations to an Exchange operated by HHS, known as the Federally Facilitated Exchange (FFE), are described as determination states, or FFE-D states. By contrast, those states that receive information from the FFE, which makes assessments of Medicaid/CHIP eligibility, but where the applicant's account is transferred to the state for the final eligibility determination, are known as assessment states, or FFE-A states.

We proposed that states will be responsible for providing the ERC with eligibility determination policies and procedures, and any case documentation requested by the ERC, which could include the account transfer (AT) file for any claims where the individual was determined eligible by the FFE in a determination state (FFE-D), or was passed on to the state by the FFE for final determination in assessment states (FFE-A).

Further, if the ERC finds that it cannot complete a review due to insufficient supporting documentation, it will expect the state to provide it. States will determine how to obtain the requested documentation (we did not propose to charge the ERC with conducting additional outreach, such as client contact) and, if unable to do so, to enable to ERC to complete the review, the ERC will cite the case as an improper payment due to insufficient documentation. In the event that additional documentation is needed for a sampled FFE-D case, we are aware that states may not have access to any other supporting documentation, aside from the AT file. For these cases, where the beneficiary's eligibility determination under review was made by the FFE, an insufficient documentation improper payment would be cited, but only included in the national improper payment rate, and not the state specific improper payment rate. We also proposed that states will be responsible for providing the ERC with direct access to their eligibility system(s). A state's eligibility system(s) (including any electronic document management system(s)) contains data the ERC must review, including application information, third party data verification results, and copies of required documentation (for example, pay stubs), and we believe that allowing the ERC direct access would best enable

it to complete its reviews in a timely and accurate manner and reduce state burden that would otherwise be required to inform the ERC's reviews.

However, to ensure that states continue to have a measure of oversight, we proposed allowing states the opportunity to review the ERC's case findings prior to their being finalized and used to calculate the national and state improper payment rate. Through a difference resolution and appeals process, states would have the opportunity to resolve disagreements with the ERC. Based on our pilot testing, we believe that open communication between the state and the ERC would best foster states' understanding of the review process and the basis for any findings.

The following is summary of the comments we received regarding our proposal to add requirements which outline the state's role in supporting the federal contractor during the PERM eligibility reviews.

Comment: Several commenters expressed the importance of continued state involvement in the eligibility reviews. The commenters noted the need for the ERC to work collaboratively with states and to allow state experts to provide assistance, resources, and support to the ERC. Additionally, one commenter noted the need for states to understand in advance how the ERC will conduct reviews and have the opportunity to review the ERC's planned review process.

Response: We agree with the commenters and believe that open communication and collaboration between the state and the ERC is essential and would best foster states' understanding of the review process and the basis for any findings. We intend to minimize state burden, but envision that states will still play an important role in supporting the federal contractor. Our PERM model pilot testing has confirmed that having a federal contractor conduct eligibility reviews is feasible as an experienced federal contractor can apply PERM guidance consistently across states while continuing to recognize unique state eligibility policies, processes, and systems. Further, through the pilots, we have developed processes to ensure that the federal contractor works collaboratively with state staff. We tasked the ERC to develop state-specific eligibility review planning documents to ensure state and CMS buy-in for the review process that will be utilized in each state.

Comment: One commenter suggested that CMS make the eligibility review procedures available to the public so that stakeholders can understand the standards and processes used to evaluate the accuracy of Medicaid and CHIP determinations.

Response: Similar to CMS' current practice for the PERM medical review and data processing review processes and procedures, we intend to make eligibility review processes and procedures available through documents available on the CMS PERM Web site.

Comment: One commenter requested that CMS incorporate a mechanism or process to determine whether the automated eligibility processes required by the Affordable Care Act are functioning accurately and whether eligibility category assignments result in the appropriate federal match rate being applied.

Response: As defined at § 431.960(d)(1), an eligibility error is an error resulting in an overpayment or underpayment that is determined from a review of a beneficiary's eligibility determination, in comparison to the documentation used to establish a beneficiary's eligibility and applicable federal and state regulations and policies, resulting in Federal and/or State improper payments. This definition will be applied regardless of whether the error was caused by automated system or caseworker processes. For the commenter's second request, we intend to review eligibility determinations for correct eligibility category assignment. We proposed to clarify in § 431.960(b)(1), (c)(1), and (d)(1) that improper payments are defined as both federal and state improper payments. We believe this change would allow us to identify federal improper payments in circumstances where states make an incorrect eligibility category assignment that would result in the incorrect FMAP being claimed by the state.

Comment: A few commenters had expressed concerns around the requirement for states to provide the case documentation needed to support the eligibility review. One commenter stated that the ERC should be responsible for providing documentation to support the eligibility reviews because they are conducting the reviews. Another commenter questioned how the ERC would obtain all information the state used to determine eligibility if the supporting documentation exists only in hard copy.

Response: As case documentation is within the state's custody and control, the responsibility for providing

documentation lies with the state. Moreover, states must provide case documentation as requested to support the eligibility determinations under review as proposed at § 431.970(a)(9). As stated in the proposed rule, if the state is unable to comply with all information submission requirements and the ERC is unable to complete the review, the payment under review may be cited as an error due to insufficient documentation. The ERC will accept both electronic and hard copy documentation.

Comment: One commenter requested that CMS allow and approve state waiver requests to maintain the PERM eligibility review responsibility, rather than transferring the responsibility to the federal contractor.

Response: To ensure the accuracy and consistency of the PERM improper payment rates, we will not allow or approve state waiver requests to maintain the PERM eligibility review responsibility. As noted in the proposed rule, the decision to transfer the PERM eligibility reviews to a federal contractor was proposed to reduce states' PERM program burden and ensure more consistent guidance interpretation, thereby reducing case review inconsistencies across states and improving eligibility processes related to case reviews and reporting.

Comment: One commenter requested that CMS include a provision requiring the review contractor to review the case according to state eligibility criteria and documented policies and procedures, as well as a provision that would prevent an error from being counted three times based on the data processing, medical, and eligibility reviews.

Response: The definition of an eligibility error at § 431.960(d)(1) states that an eligibility error is an error resulting in an overpayment or underpayment that is determined from a review of a beneficiary's eligibility determination, in comparison to the documentation used to establish a beneficiary's eligibility and applicable federal and state regulations and policies, resulting in Federal and/or State improper payments. Thus, the ERC will be conducting the eligibility reviews in accordance with applicable federal, as well as, state regulations and policies. Separate definitions for data processing and medical review errors are also detailed at § 431.960(b) and (c), respectively, which the ERC will use to conduct reviews. As the three payment error definitions are distinct, a single error would be prevented from being counted three times.

In addition to the comments above, we also received many comments

supporting the transfer of the PERM eligibility review responsibility to a federal contractor, and therefore, are finalizing as proposed.

9. Eligibility Review Procedures

As discussed, we proposed that a federal contractor conduct the eligibility case reviews, and states' responsibilities would therefore be limited. Because we proposed state responsibilities at § 431.970, we proposed to remove § 431.974.

We did not receive any comments on this proposal to remove § 431.974, and therefore, we are finalizing as proposed.

10. Eligibility Sampling Plan

We proposed to remove § 431.978, because the ERC will conduct the eligibility reviews and states will no longer be required to submit a sampling plan. In place of the sampling plan, the ERC will draft state-specific eligibility case review planning documents outlining how it will conduct the eligibility review, including the relevant state-specific eligibility policy and system information.

We did not receive any comments on this proposal to remove § 431.978, and therefore, we are finalizing as proposed.

11. Eligibility Review Procedures

We proposed to remove § 431.980; this section presently specifies the review procedures required for states to follow while performing the PERM eligibility component reviews. States will no longer be required to conduct the PERM eligibility component reviews, because the ERC will conduct the eligibility reviews.

We did not receive any comments on this proposal to remove § 431.980, and therefore, we are finalizing as proposed.

12. Eligibility Case Review Completion Deadlines and Submittal of Reports

We proposed to remove § 431.988; this section presently specifies states' requirements and deadlines for reporting PERM eligibility review data, which functions we proposed to transition to an ERC.

We did not receive any comments on this proposal to remove § 431.988, and therefore, we are finalizing as proposed.

13. Payment System Access Requirements

The Claims Review Contractor (RC) currently conducts PERM reviews on FFS and managed care claims for the Medicaid program and CHIP, and is required to conduct Data Processing (DP) reviews on each sampled claim to validate that the claim was processed correctly based on information found in

the state's claim processing system and other supporting documentation maintained by the state. We believe that, in order for the RC to review claims during the review cycle, reviewers would need remote or on-site access to appropriate state systems. If the RC is unable to review pertinent claims information, and the state is not able to comply with all information submission and systems access requirements as specified in the proposed rule, the payment under review may be cited as an error due to insufficient documentation.

To facilitate the RC's reviews, we proposed that states grant it access to systems that authorize payments, including: FFS claims payments; Health Insurance Premium Payment (HIPP) payments; Medicare buy-in payments; aggregate payments for providers; capitation payments to health plans; and per member per month payments for Primary Care Case Management (PCCM) or non-emergency transportation programs. We proposed that states also grant the RC access to systems that contain beneficiary demographics and provider enrollment information to the extent such information is not included in the payment system(s), and to any imaging systems that contain images of paper claims and explanation of benefits (EOBs) from third party payers or Medicare.

Experience has demonstrated that some states have allowed the RC only partial and/or untimely systems access, which we believe has led to a slower review process. Based on our discussions with the states, we believed they are sometimes permitting limited systems access due to a lack of processes to grant access (for example, requiring contractors to complete access forms and training) rather than state bans on providing outside contractors with access due to privacy or cost concerns. Therefore, we proposed adding paragraphs (c) and (d) to § 431.970, which will require states to provide access to appropriate and necessary systems.

Comment: Many commenters stated concerns surrounding the proposed requirement for states to provide federal contractors with direct access to all eligibility systems necessary to conduct the eligibility review, all payment systems, any systems that include beneficiary demographic information and/or provider enrollment information necessary to conduct the medical and data processing reviews, any document imaging systems, and systems that house the results of third party data matches. The majority of concerns

stemmed from the need for data privacy and security, as well as a concern around the data that can be shared and/or provided to federal contractors.

Response: Our contractors are subject to stringent federal security standards, including compliance with HIPAA requirements, and their systems are subject to annual security audits to ensure that protected health information (PHI) and personally identifiable information (PII) used in the PERM program is protected. Further, each CMS contractor is subject to any state-specific security requirements related to the access and use of PHI and PII. This includes entering into data use agreements and completion of any other security-related protocol required by the states. This final rule requires that contractors be provided direct access to any necessary state systems required to conduct Medicaid and CHIP claim and eligibility reviews and that access can be provided through remote means (preferred) or through onsite access. However, we understand that some data elements within a system, such as the IRS income amounts, cannot be viewed by the ERC due to rules around access to federal tax information (FTI). CMS and our contractors will work with states at the start of each cycle on the identification of systems needed for PERM reviews and potential access challenges.

Comment: One commenter requested that CMS clarify in regulation the systems for which the contractor would need direct access.

Response: Proposed § 431.970 outlined the system access requirements for federal contractors. This includes all payment system(s) necessary to conduct the medical and data processing review, including the Medicaid Management Information System (MMIS), any systems that include beneficiary demographic and/or provider enrollment information, and any document imaging systems that store paper claims. This also includes all eligibility system(s) necessary to conduct the eligibility review, including any eligibility systems of record, any electronic document management system(s) that house case file information, and systems that house the results of third party data matches. Because the number and types of systems differ between states, we will work with each state to determine which systems contractors will need direct access to meet the requirements of § 431.970.

Comment: One commenter requested that CMS clarify if there is a difference between the terms "direct access" and "remote or on-site access." The

commenter stated that CMS should allow states discretion to provide any combination of direct, remote, or on-site systems access.

Response: The terms "direct access" and "remote or on-site access" are equivalent. States are required to provide direct systems access to federal contractors. While we encourage and prefer states to provide remote access where possible, both remote and on-site access will meet the requirements of § 431.970.

Comment: Many commenters were concerned about the time it would take to train federal contractors to navigate numerous systems, ultimately increasing state burden. Commenters requested that CMS re-evaluate the efficiency of providing direct access to federal contractors.

Response: We recognize that the time and resources that could be required by a state to train federal contractors in navigating numerous systems will be increased initially. However, following this initial training, state burden should be reduced over the duration of the PERM cycle. Through previous PERM cycles, as well as the PERM model pilots, experience has demonstrated that when states have allowed federal contractors direct systems access, it has led to a more timely and less burdensome review process.

Comment: One commenter requested that CMS clarify if there were any alternatives should a state not provide direct access to the eligibility system.

Response: If the state is unable to comply with all information submission and systems access requirements and the ERC is unable to complete the review, the payment under review may be cited as an error due to insufficient documentation.

In addition to these comments, we received several comments supporting our proposal to require states grant direct systems access to federal contractors, and therefore, we are finalizing § 431.970(c) and (d) as proposed.

14. Universe Definition

To meet IPERIA requirements, the samples used for PERM eligibility reviews must be taken from separate universes: one that includes Title XIX Medicaid dollars, and one that includes Title XXI CHIP dollars. Section 431.978(d)(1) currently defines the Medicaid and CHIP active universes as all active Medicaid or CHIP cases funded through Title XIX or Title XXI for the sample month, with certain exclusions. Developing an accurate and complete universe is essential to

developing a valid, accurate improper payment rate.

In previous PERM cycles, sampling universe development has been one of the most difficult steps of the eligibility review. Varying data availability and system constraints have made it challenging to maintain consistency in state-developed eligibility universes; developing the eligibility universe may require substantial staff resources, and the process may take several data pulls that are often conducted by IT staff or outside contractors not closely involved in the PERM eligibility review process.

During the PERM model pilots, we tested three PERM eligibility review universe definition options, including defining the universe by: (1) Eligibility determinations and redeterminations (that is, a universe of eligibility decisions); (2) actual beneficiaries or recipients (that is, a universe of eligible individuals); and (3) claims/payments (that is, a universe of payments made). We found that the third approach, defining the universe by the claims/payments, was best; PERM was designed to meet the IPERIA requirements of calculating a national Medicaid and CHIP improper payment rate, so having the eligibility reviews tied directly to a paid claim ensures that PERM only reviews those beneficiaries or recipients who have had services paid for by the state Medicaid or CHIP agency. Accordingly, for the PERM eligibility review active universe we proposed using the definition at § 431.972(a), and deleting the current PERM eligibility review universe requirements in § 431.974 and § 431.978. The PERM claims component requires state submission of Medicaid and CHIP FFS claims and managed care payments on a quarterly basis; state submission responsibilities are defined under § 431.970. These claims and payments are rigorously reviewed by the federal statistical contractor, and the process has extensive, thorough quality control procedures that have been used for several PERM cycles and have been well-tested.

We believe that this universe definition leverages the claims component of PERM and supports efficient use of resources, as the universe would already be developed on a consistent basis for the PERM claims component. By this proposed change, eligibility reviews using a claims universe would be tied to payments and be more consistent with IPERIA, state burden would be minimized by harmonizing PERM claims and eligibility universe development, and federal and state resources would no longer be spent on eligibility reviews

that potentially could not be tied to payments (for example, eligibility reviews conducted on beneficiaries that did not receive any services).

Through our pilot testing, we have also determined that the claims universe does not result in a substantially different rate of case error. However, sampling from this universe did result in a higher proportion of non-MAGI cases because enrollees in such eligibility categories are likely to have higher health care service utilization, and therefore, have more associated FFS claims. Because PERM is designed to focus on improper payments, we believe it is appropriate to use a sample that focuses on individuals who are linked to the bulk of Medicaid and CHIP payments. However, because eligibility will be reviewed for both FFS claims and managed care capitation payments, MAGI cases will be subject to a PERM eligibility review, primarily through the review of eligibility for individuals who have managed care capitations payments on their behalf, as many states have chosen to enroll individuals in MAGI eligibility categories in managed care. Further, states can choose to focus on further Medicaid and CHIP reviews of MAGI cases in the proposed MEQC pilot reviews they would conduct during their off-year pilots.

While it is possible for a claim to be associated with a negative case, as mentioned previously, the claims universe does not support a negative PERM eligibility case rate. Because IPERIA focuses on payments, the statute does not require determining a negative case rate. The proposed MEQC pilot reviews that states will conduct on off-years would be used to review Medicaid and CHIP negative cases.

The following is summary of the comments we received regarding our proposal to change the universe definition, which would no longer include a separate negative case review in PERM.

Comment: Several commenters expressed concern around the removal of the negative case reviews from PERM. Many commenters were concerned about the oversight of these cases if not reviewed by PERM, and recommended CMS reinstate negative case reviews as part of the PERM program.

Response: The purpose of the PERM program is to identify improper payments. We recognize the importance of negative case oversight and have proposed to do so through the MEQC pilot program. This important oversight will help assure states are not incorrectly denying coverage to individuals, who are in fact eligible to receive Medicaid/CHIP benefits.

However, as recommended by the comment below, we have added PERM CAP requirements to require states to evaluate whether actions states take to reduce eligibility errors will also avoid increases in improper denials.

Comment: One commenter suggested additional PERM CAP requirements for states that would require consideration of whether actions states take to reduce eligibility errors will also avoid increases in improper denials, because the PERM universe will no longer include a review of negative cases to determine whether there were inappropriate denials.

Response: We agree with this comment and have added language to § 431.992 to include that states will be required to evaluate whether actions states take to reduce eligibility errors will also avoid increases in improper denials.

Comment: One commenter stated that denied claims should be removed from the universe of claims because denied claims have no federal funds attached. The commenter also questioned whether, if denied claims are included in the universe, there is a timeframe that the eligibility determinations associated with denied claims would not be reviewed and/or dropped, as the determination under review could have taken place a number of years earlier.

Response: One of the primary benefits of moving to a single sample to support medical reviews, data processing reviews, and eligibility reviews for the PERM program is to streamline the universe submission and sampling process and select just one sample from a universe of paid and denied FFS and managed care claims and payments. This effort will minimize state burden and better align the claims and eligibility review process for the PERM program. Further, based on IPERIA requirements, the PERM program must review for potential over- or under-payments. Denied claims are included in the PERM claims universe to account for possible underpayments. We will not make any adjustments in regulation regarding the inclusion of denied claims in the PERM universe nor to the potential for those claims to receive an eligibility review. However, we appreciate the commenter's concern regarding the sampling of claims where the last eligibility action for the individual associated with the claim occurred years earlier than the claim paid date. During the first 2 rounds of the PERM model pilots, we conducted an analysis to determine the average length of time between the claim paid date and the claim date of service to determine if a significant lag between

those two dates would result in eligibility reviews that occurred more than 1 to 2 years prior to the claim paid date.

This analysis showed that the average amount of time between a claim paid date and a claim date of service in the PERM sampled claims reviewed was approximately 40 to 45 days. Additionally, on average, the oldest eligibility actions were approximately 13 months prior to claim paid date. Further, to date, our pilot work has found no issues preventing the completion of eligibility reviews regardless of the claim paid date or claim date of service. We will continue to monitor the eligibility review of denied claims during Round 5 of the Medicaid and CHIP Eligibility Review Pilots, as well as during the initial cycles when PERM eligibility resumes. If issues are identified related to the review of denied claims for eligibility or, more generally, with the review of older claims, we will issue subregulatory guidance.

As a result of the comments, we are revising § 431.992 to include a state requirement to evaluate whether actions states take to reduce eligibility errors will also avoid increases in improper denials. Moreover, we have also received several comments supporting our proposed universe definition, and therefore, we are finalizing this as proposed.

15. Inclusion of FFE–D Cases in the PERM Review

As previously noted, § 431.10(c)(1)(i)(A)(3) permits state Medicaid agencies to delegate authority to determine eligibility for all or a defined subset of individuals to the Exchange, including Exchanges operated by a state or by HHS. We proposed that, in FFE–D states, cases determined by the FFE (referred to as FFE–D cases) could be reviewed if a FFS claim or managed care payment for an individual determined eligible by the FFE is sampled. Although FFE–D states are required to maintain oversight of their Medicaid/CHIP programs per § 435.1200(c)(3), they also enter into an agreement per § 435.1205(b)(2)(i)(A) by which they must accept the determinations of Medicaid/CHIP eligibility based on MAGI made by another insurance affordability program (in this case, the FFE).

Federal regulations permit states to delegate authority for MAGI-based Medicaid and CHIP eligibility determinations to the FFE and require them to accept those determinations. States have an overall responsibility for oversight of all Medicaid and CHIP

eligibility determinations, but, with respect to the FFE delegation, they are required to accept FFE determinations without further review or discussion on a case-level basis, making it difficult for states to address improper payments on a case-level basis. Therefore, we proposed that case-level errors resulting solely from an FFE determination of MAGI-based eligibility that the state was required to accept be included only in the national improper payment rate, not the state rate. Conversely, we proposed that errors resulting from incorrect state action taken on cases determined and transferred from the FFE, or from the state's annual redetermination of cases that were initially determined by the FFE, be included in both state and national improper payment rates. Examples of errors that we proposed will be included in both state and national improper payment rates include, but are not limited to: (1) Where a case is initially determined and transferred from the FFE, but the state then fails to enroll an individual in the appropriate eligibility category; and (2) errors resulting from initial determinations made by a state-based Exchange.

We proposed revisions to § 431.960(e) and § (f) to clarify that we would distinguish between cases that are included in a state's, and the national, improper payment rate. Although we proposed this distinction for improper payment measurement program purposes, this distinction does not preclude the single state agency from exercising appropriate oversight over eligibility determinations to ensure compliance with all federal and state laws, regulations and policies. We also proposed revisions to § 431.992(b) to clarify that states would be required to submit PERM corrective actions only for errors included in state improper payment rates.

We did not receive any comments on this proposal to not include case-level errors resulting solely from an FFE determination of MAGI-based eligibility in the state improper payment rate, and therefore, we are finalizing as proposed.

16. Sample Size

Establishing adequate sample sizes is critical to ensuring that the PERM improper payment rate measurement meets IPERIA statistical requirements. In accordance with IPERIA, PERM is focused on establishing a national improper payment rate, which must meet the precision level established in OMB Circular A–123, which is a 2.5 percent precision level at a 90 percent confidence interval. Although not required by IPERIA, as an additional

goal we have always strived to achieve state level improper payment rates within a 3 percent precision level at a 95 percent confidence interval. However, as discussed in the Regulatory Impact Analysis, we recognize achieving this level of precision in all states poses some challenges and is not always possible.

Previously, state-specific sample sizes were calculated prior to each cycle and the national annual sample size was the aggregate of the state-specific sample sizes. State-specific sample sizes were based on past state PERM improper payment rates. We proposed establishing a national annual sample size that would meet IPERIA's precision requirements at the national level, and then distributing the sample across states to maximize precision at the state level, where possible. We also proposed that the state-specific sample sizes would be chosen to maximize precision based on state characteristics, including a history of high expenditures and/or past state PERM improper payment rates. We recognize that the precision of past estimates of state-specific improper payment rates has varied. We requested public comment on this proposed approach, its benefits, limitations, and any potential alternatives. We believe that, relative to our prior approach, the proposed approach would more effectively measure and reduce national improper payments and would also provide more stable state-specific sample sizes, as the sample size would be less responsive to changes in improper payment rates from cycle to cycle. A more stable state-specific sample size may assist with state level planning. Further, it will allow us to exercise more control over the PERM program's budget by establishing a national sample size. On the other hand, like its predecessor, the proposed approach may not yield improper payment estimates at the state level within a 3 percent precision level at a 95 percent confidence interval for all states (due to underpowered sample size). We will develop specific sampling plans for PERM cycles that occur after publication of the final rule. We will continue to calculate a national improper payment rate within a 2.5 percent precision level at a 90 percent confidence interval as required by IPERIA. Likewise, we will continue to strive to achieve state improper payment rates within a 3 percent precision level at a 95 percent confidence interval precision. In the future, as information improves or new priorities are identified, we may identify additional factors that should be taken

into account in developing state-specific sample sizes.

In practice, we anticipate having the ability to vary the number of data processing, medical, and eligibility reviews performed on each of the sampled claims. Under this approach, each sampled claim may not undergo all three types of reviews, which would allow us to more efficiently allocate the types of reviews performed. Conducting more reviews on payments that are likely to have problems gives us better information to implement effective corrective actions, which could assist in reducing improper payments. For example, after eligibility reviews resume, we may determine that there are few eligibility improper payments for clients associated with managed care claims; thus, there might be a limited benefit to conducting eligibility reviews on all sampled managed care claims, and we might reduce the number of those reviews. This approach would allow us to optimize PERM program expenditures so we do not waste resources conducting reviews unlikely to provide valuable insight on the causes of improper payments.

We note above that conducting reviews on areas more likely to have problems results in more information to inform corrective actions versus conducting more reviews on areas that are likely to be correct. It is important to note that state corrective actions are not impacted by varying levels of state-specific improper payment rate precision. As we describe later in this final rule, states are required to submit corrective action plans that address all improper payments and deficiencies identified.

The following is a summary of the comments we received regarding our proposals to: (1) Establish a national annual sample size that would meet IPERIA's precision requirements at the national level, and then distributing the sample across states to maximize precision at the state level, where possible, and (2) choose state-specific sample sizes that would maximize precision based on state characteristics, including a history of high expenditures and/or past state PERM improper payment rates.

Comment: Commenters requested clarification around the phrase "In practice, we anticipate having the ability to vary the number of data processing, medical, and eligibility reviews performed on each of the sampled claims. Under this approach, each sampled claim may not undergo all three types of reviews, which would allow us to more efficiently allocate the types of reviews performed."

Commenters questioned when this approach would first go into effect, and were concerned with how this allocation of reviews would be determined.

Response: The new sample size methodology, where the national sample will be distributed across states and when sampled claims will receive some combination of data processing (DP), medical review (MR), and eligibility review, will go into effect upon the effective date of the final rule. The first PERM measurement impacted by the changes in this regulation, including the sample size methodology change, will be Cycle 1 states, whose review period is from July 1, 2017, through June 30, 2018. Beginning with these reviews, we anticipate setting the number of DP, MR, and eligibility reviews at the national level, which would then be distributed across states.

Comment: Many commenters requested clarification of the phrase "Conducting more reviews on payments that are likely to have problems gives us better information to implement effective corrective actions, which could assist in reducing improper payments." Commenters stated that this approach would inaccurately overstate the error rate, target eligibility cases that are more likely to have problems, and not produce a statistically valid sample.

Response: It is our goal to select a sample that is both representative of the universe of claims in the State and is descriptive enough that potential error causes will be present in the sample so they can be addressed by the State in corrective actions. All claims sampled are applied the respective sampling weight that accurately reflects the state's improper payment rate. That is, if the PERM program were to sample high risk claims at a greater frequency compared to other claims, the high risk claims would receive a relatively lower statistical weight, which prevents overstating of a state's improper payment rate. This weighting process helps make sure the resulting improper payment rate is statistically valid and representative of the universe of claims.

Comment: Two commenters requested that CMS provide detailed information of an estimated state-specific sample size and the method used to make that determination. One commenter requested that CMS allow states to enhance their state-specific sample based on the state's characteristics and suggested that defining the state's sample based on high expenditure claims and prior payment errors does not reflect the overall performance of the state.

Response: We will continue to strive to achieve state level improper payment rates within a 3 percent precision level at a 95 percent confidence interval. We will distribute the national annual sample across states to maximize precision at the state level, where possible. State-specific sample sizes would be chosen to maximize precision based on state characteristics, including a history of high expenditures and/or past state PERM improper payment rates. In the future, as information improves or new priorities are identified, we may identify additional factors that should be taken into account in developing state-specific sample sizes. Therefore, more detailed statistical methodology information will be made available in a subregulatory form so that we can make updates to the methodology as additional factors are identified.

After considering the comments, we did not make any revisions to the regulatory text, and therefore, are finalizing as proposed.

17. Data Processing, Medical, and Eligibility Improper Payment Definitions

We proposed clarifying in § 431.960(b)(1), (c)(1), and (d)(1) that improper payments are defined as both federal and state improper payments. We believe this change would allow us to cite federal improper payments in circumstances where states make an incorrect eligibility category assignment that would result in the incorrect FMAP being claimed by the state. Previously, improper payments were only cited if the total computable amount—the federal share plus the state share—was incorrect. Under the Affordable Care Act, beneficiaries in the newly eligible adult group receive a higher FMAP rate than other eligibility categories. As a result, incorrect enrollment of an individual in the newly eligible adult category may result in improper federal payments even though the total computable amount may be correct. Although there were eligibility categories that could receive higher FMAP rates previously, the size of the newly eligible adult category makes it critical for us to have the ability to cite federal improper payments to achieve an accurate PERM improper payment rate.

The following is summary of the comments we received regarding our proposal to clarify in § 431.960(b)(1), (c)(1), and (d)(1) that improper payments are defined as both federal and state improper payments.

Comment: A commenter requested we modify the definition of federal

improper payments, stating if the total computable payment is correct that the payment should not be cited as an error.

Response: We believe this proposed change would allow us to state federal improper payments in circumstances where states make an incorrect eligibility category assignment that would result in the incorrect federal medical assistance percentage (FMAP) being claimed by the state. Previously, improper payments were only stated if the total computable amount—the federal share plus the state share—was incorrect. Under the Affordable Care Act, beneficiaries in the newly eligible adult group receive a higher FMAP rate than other eligibility categories. As a result, incorrect enrollment of an individual in the newly eligible adult category may result in improper federal payments even though the total computable amount may be correct. Although there were eligibility categories that could receive higher FMAP rates previously, the size of the newly eligible adult category makes it critical for us to have the ability to state federal improper payments to achieve an accurate PERM improper payment rate.

Comment: Commenters requested clarification of the eligibility error definition in regard to the phrase “lacked or had insufficient documentation in his or her case record,” specifically regarding whether or not states have the opportunity to provide the missing documentation that proves the eligibility determination was correct before it is determined an error.

Response: States are required to provide documentation to support their eligibility determination. We intend to accept documentation to support accurate payments that is provided in time to be included in the improper payment rate calculation and meets criteria set forth by CMS in future subregulatory guidance regarding the provision of documentation for eligibility reviews.

Comment: One commenter stated the eligibility error definition for both PERM and MEQC was likely to increase error rates, as citing errors when a case does not contain sufficient documentation to support the eligibility determination decision overlooks the possibility that the documentation could not be attained for legitimate reasons. The commenter also stated that, currently, these cases are removed from the sample as the inaccuracy of the decision cannot be proven and requests CMS to continue its practice of excluding these cases from the sample unit.

Response: We respectfully disagree with the commenter. We must include cases of insufficient documentation as improper payments to comply with OMB’s implementing guidance for IPERIA, which states that “when an agency’s review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an improper payment.” Consistent with this guidance, PERM has never allowed for cases of insufficient or lack of documentation to be excluded.

Comment: One commenter requested that CMS clarify if PERM eligibility errors would include both caseworker and systems errors.

Response: The definition of an eligibility error at § 431.960(d)(1) states that an eligibility error is an error resulting in an overpayment or underpayment that is determined from a review of a beneficiary’s eligibility determination, in comparison to the documentation used to establish a beneficiary’s eligibility and applicable federal and state regulations and policies, resulting in Federal and/or State improper payments. This definition will be applied regardless of whether the error finding was caused by a caseworker or system.

In addition to the comments above, we also received several comments supporting our proposal to clarify in § 431.960(b)(1), (c)(1), and (d)(1) that improper payments are defined as both federal and state improper payments. Therefore, we are finalizing § 431.960 as proposed.

18. Difference Resolution and Appeals Process

Because we proposed to use an ERC to conduct the eligibility case reviews, we likewise proposed that the ERC conduct the eligibility difference resolution and appeals process, which would mirror how that process is conducted with respect to FFS claims and managed care payments. The difference resolution and appeals process used for the FFS and managed care components of the PERM program is well developed and has allowed us to adequately resolve disagreements between the RC and states. We have revised § 431.998 to include the proposed eligibility changes for the difference resolution and appeals process.

Additionally, we proposed deleting the statement in the regulation text currently at § 431.998(d) about CMS recalculating state-specific improper payment rates, upon state request, in the event of any reversed disposition of

unresolved claims; Instead proposing that the recalculation be performed whenever there is a reversed disposition, such that no state request is needed.

The following is summary of the comments we received regarding our proposal for the ERC to conduct the eligibility difference resolution and appeals.

Comment: One commenter requested that CMS include in regulation the requirements for the ERC to respond and collaborate with states to resolve differences in a timely manner.

Response: PERM review contractors have requirements in their contracts for responding to state requests for difference resolutions in a timely manner. Currently, the PERM review contractors are contractually required to respond to state requests for difference resolutions in 15 days. Requirements such as state collaboration are also included in these contracts and the contractors are held accountable to be in compliance. Additionally, through the PERM model pilots we learned that state collaboration and communication are essential in making the new eligibility review process with the ERC a success, which is also a priority to us.

Comment: A commenter requested that CMS re-evaluate the time allowed for the difference resolution and appeals processes, especially for the eligibility component, as the current time allowances are insufficient. The commenter recommended that CMS allow for 60 calendar days for difference resolution requests and 30 calendar days for appeal requests.

Response: We find the request to re-evaluate the difference resolution and appeals timeframes reasonable, but disagree with the specific timeframes recommended by the commenter. Instead, we will extend the difference resolution time allowance to 25 business days and the appeal time allowance to 15 business days, which will allow states more time to research errors while still allowing the PERM process to be completed within a reasonable timeframe.

Comment: One commenter requested clarification as to whether or not CMS would be able to complete all recalculated state improper payment rates to enable them to be published in the AFR and state report.

Response: Changing the PERM review period provides states and CMS additional time to complete the work related to each PERM cycle prior to the annual improper payment rate publication in the AFR and state reports. Therefore, we anticipate the need for state improper payment rate

recalculations to be limited. Per § 431.998(d), all differences that are not overturned in time for improper payment rate calculation will be considered as errors in the improper payment rate calculation to meet the reporting requirements of the IPIA (as amended). In the event of any reversed disposition of unresolved claims, a state improper payment rate recalculation will be performed.

Comment: One commenter requested that CMS clarify the types of reports that will be provided to states to determine if a difference resolution or appeal should be pursued or requested for findings. Additionally, the commenter requested that detailed case information will be needed, not only for determining whether or not to file a difference resolution/appeal, but for developing and implementing corrective actions.

Response: As proposed, the difference resolution and appeals process would mirror how that process is conducted for FFS and managed care payments. Detailed information on the payment under review, as well as the reason for the error/deficiency citation, is provided to allow states to determine whether they should request difference resolution and/or an appeal, as well as develop appropriate corrective actions.

As a result of the comments, we have revised § 431.998(b) and (d) to include the new time allowances for both difference resolution and appeal requests. We are finalizing all other provisions this section as proposed.

19. Corrective Action Plans

Under § 431.992, states are required to submit CAPs to address all improper payments and deficiencies found through the PERM review. We proposed that states would continue to submit CAPs that address eligibility improper payments, along with improper payments found through the FFS and managed care components. We proposed to revise § 431.992(a) to clarify that states would be required to address all errors included in the state improper payment rate at § 431.960(f)(1).

We proposed to revise § 431.992 to provide additional clarification for the PERM CAP process. We proposed minor revisions to the regulatory text to reflect the current corrective action process and provide additional state requirements, consistent with the CHIPRA. Proposed revisions include replacing “major tasks” at § 431.992(b)(3)(ii)(A) with “corrective action,” to improve clarity. Other proposed clarifications would also be provided at § 431.992(b)(3)(ii)(A) through (E).

We also proposed adding language to clarify the state responsibility to evaluate corrective actions from the previous PERM cycle at § 431.992(b)(4), and a requirement for states, annually and when requested by CMS, to update us on the status of corrective actions. We proposed to request updates on state corrective action implementation progress on an annual basis, a frequency that would enable us fully monitor corrective actions and ensure that states are continually evaluating the effectiveness of their corrective actions.

Additionally, we proposed to add language in § 431.992 to specify further CAP requirements should a state’s PERM eligibility improper payment rate exceed the allowable threshold of 3 percent per section 1903(u) of the Act for consecutive PERM years. This proposal only pertains to a state’s additional CAP requirements related to the PERM eligibility improper payment rate, and does not extend to the FFS and managed care components. As the allowable threshold for eligibility is set by section 1903(u) of the Act, this will not change from year to year. The improper payment rate targets for FFS and managed care are not constant, therefore, it is not judicious to hold states accountable to meet a target that is variable.

We proposed to require states whose eligibility improper payment rates exceed the 3 percent threshold for consecutive PERM years to provide status updates on all corrective actions on a more frequent basis, as well as include more details surrounding the state’s implementation and evaluation of all corrective actions, than would be required for those states that did not have eligibility improper payment rates over the 3 percent threshold for consecutive PERM years. As noted above, we anticipate typically requesting updates on corrective actions on an annual basis, however, for those states with consecutive PERM eligibility improper payment rates above the allowable threshold, we proposed to require updates every other month. Such states would also be required to submit information about any setbacks and provide alternate corrective actions or manual workarounds, in the event that their original corrective actions are unattainable or no longer feasible. This would ensure that states have additional plans in place, if the original corrective action cannot be implemented as planned. Also, states would be required to submit actual examples demonstrating that the corrective actions have led to improvements in operations, and explanations for how these improvements are efficacious and

will assist the state to reduce both the number of errors cited and the state’s next PERM eligibility improper payment rate. Moreover, we proposed that states be required to submit an overall summary that clearly demonstrates how the corrective actions planned and implemented would provide the state with the ability to meet the 3 percent threshold upon their next PERM eligibility improper payment rate measurement.

The following is summary of the comments we received regarding our proposals to revise § 431.992 by (1) clarifying that states would be required to address all errors included in the state improper payment rate at § 431.960(f)(1); (2) adding language to clarify the state responsibility to evaluate corrective actions from the previous PERM cycle at § 431.992(b)(4), and a requirement for states, annually and when requested by CMS, to update us on the status of corrective actions; and (3) adding language to specify further CAP requirements should a state’s PERM eligibility improper payment rate exceed the allowable threshold of 3 percent per section 1903(u) of the Act for consecutive PERM years.

Comment: One commenter requested that CMS impose a 1-year timeframe for completing the corrective actions, with tighter timeframes when feasible.

Response: Specific deadlines for addressing errors and deficiencies, as well as for implementing corrective actions, are highly dependent on the nature of the problem, and the kind and extent of the corrective action needed. Therefore, we do not believe that imposing a timeframe for states’ completing corrective actions would be feasible.

Comment: One commenter suggested CMS clarify that the evaluation look-back period applies to all previous CAPs and is not limited to only the CAP from the most recent PERM measurement.

Response: Implementing such provisions would require states to report on corrective actions that could potentially be no longer relevant. In the event that a corrective action was not implemented by the state, similar findings would be identified during their MEQC pilots and PERM reviews, and, thus, have to meet MEQC CAP and PERM CAP requirements. Additionally, should a state exceed the 3 percent threshold for consecutive PERM years, more stringent CAP requirements are required per § 431.992(e).

As a result of the comments, and as previously mentioned in the responses to commenter concerns regarding the exclusion of negative case reviews from

PERM's review, we are revising § 431.992 to include that states be required to evaluate whether actions states take to reduce eligibility errors will also avoid increases in improper denials in their PERM CAPs. Additionally, we also received several comments supporting the proposed changes to § 431.992 and are therefore, finalizing all other provisions of § 431.992 as proposed.

20. PERM Disallowances

As previously stated regarding MEQC Disallowances, we proposed to require states to use PERM to meet the requirements of section 1903(u) of the Act in their PERM years, and to no longer require the proposed MEQC pilot program to satisfy the requirements of section 1903(u) of the Act. We proposed to require states to use PERM to meet section 1903(u) of the Act requirements, as this approach has been supported by the CHIPRA through its certain data substitution authorization between the PERM and MEQC programs. Moreover, requiring the PERM program to satisfy IPERIA requirements and requiring a separate program to satisfy the erroneous excess payment measurement and payment reduction/disallowance requirements of section 1903(u) of the Act, when PERM is capable of meeting the requirements of both, would be contrary to the CHIPRA's requirement to harmonize PERM and MEQC. Therefore, based on the ability of the PERM program to meet both the requirements of section 1903(u) of the Act and IPERIA, we proposed that in a state's PERM year, a state's PERM eligibility improper payment rate be used to satisfy both IPERIA's improper payment requirements and 1903(u) the Act's erroneous excess payments and payment reduction/disallowance requirements.

If a state's PERM eligibility improper payment rate is above the 3 percent allowable threshold per section 1903(u) of the Act, it would be subjected to potential payment reductions and disallowances. However, if the state has taken the action it believed was needed to meet the threshold and still failed to achieve that level, the state may be eligible for a good faith waiver as outlined in § 431.1010. Essential elements of a state's showing of a good faith effort include the state's participation in the MEQC pilot program in accordance with subpart P (§ 431.800 through § 431.820) and implementation of PERM CAPs in accordance with § 431.992.

Absent CMS's approval, a state's failure to comply with the requirements of both the MEQC pilot program and

PERM CAP would be considered a failure to demonstrate a good faith effort to reduce its eligibility improper payment rate. Again, absent our approval, we would not grant a good faith waiver for any state that either does not comply with the MEQC pilot program requirements or does not implement a PERM corrective action plan. We also proposed that the requirements under section 1903(u) of the Act would not become effective until a state's second PERM eligibility improper payment rate measurement has occurred, as an earlier effective date would not give states a chance to demonstrate, if needed, a good faith effort.

Under this proposed regulation, we would reduce a state's FFP for medical assistance by the percentage by which the lower limit of the state's eligibility improper payment rate exceeds the 3 percent threshold should a state fail to demonstrate a good faith effort. We proposed to use the lower limit of the improper payment rate, because we believe that utilizing the lower limit of the error rate for disallowance purposes will assist in ensuring there is reliable evidence that a state's error rate exceeds the 3 percent threshold. This approach addresses the varying levels of state-specific improper payment rate precision as discussed in the sample size section above. Therefore, we proposed to add § 431.1010, which establishes rules and procedures for payment reductions and disallowances of FFP in erroneous medical assistance payments due to eligibility improper payments, as detected through the PERM program. Federal medical assistance funds include all service-based fee-for-service, managed care, and aggregate payments which are included in the PERM universe. Exclusions from the federal medical assistance funds for disallowance purposes include non-service related costs (for example, administrative, staffing, contractors, systems) as well as certain payments for services not provided to individual beneficiaries such as Disproportionate Share Hospital (DSH) payments to facilities, grants to State agencies or local health departments, and cost-based reconciliations to non-profit providers and Federally-Qualified Health Centers (FQHCs). If expenditures included in the PERM universe are adjusted, we may also need to adjust the universe definition to meet program needs.

The following is summary of the comments we received regarding our proposal for PERM to meet section 1903(u) of the Act in state's PERM years.

Comment: Several commenters were concerned with whether the 3 percent eligibility improper payment threshold was realistic and reasonable given the changes to the PERM program. Additionally, many of those commenters requested that CMS demonstrate the validity of this figure to ensure that states would not be inappropriately penalized as a result of these substantial changes.

Response: The 3 percent threshold for eligibility-related improper payments in any fiscal year is established by section 1903(u) of the Act. Payment reductions/disallowances become effective on and after July 1, 2020, at which time states, within their respective PERM cycles, will be reviewed for the second time under this final rule.

Comment: One commenter stated that CMS should revisit the establishment of the 3 percent threshold, as, historically, MEQC processes allowed for the dropping of undetermined cases, wherein PERM will include undetermined cases among the errors.

Response: Historically, MEQC allowed for the dropping of undetermined cases due to the nature of the required MEQC review that made undetermined cases likely to be prevalent. MEQC required states to determine if cases were eligible for services during all or parts of a month under review. Under MEQC, state agencies were required to collect and verify all information necessary to determine eligibility, including conducting field investigations and in-person beneficiary interviews. However, under PERM, the ERC will review the last action performed by the state that resulted in the eligibility for the beneficiary on the date of service associated with the sampled claim. Documentation and record keeping requirements relevant to state determinations of eligibility are outlined in federal regulations, and, therefore, states should be maintaining information required for review. Thus, eligibility errors will continue to include cases that lacked or had insufficient documentation to make a definitive review decision as defined in § 431.960(d)(2)(iii).

Comment: A few commenters requested that CMS show how disallowances would be calculated and to provide an example.

Response: For each state, along with the improper payment rate, we calculate a 95 percent confidence interval, which has a lower limit and an upper limit. Under the proposed regulation, if a state's eligibility error rate is above the 3 percent allowable threshold (as established by section 1903(u) of the

Act), and the state fails to demonstrate a good faith effort in reducing its eligibility improper payment rate, then further action will be taken. Using the lower limit of the state's eligibility improper payment rate, the state's FFP for medical assistance will be reduced by the amount that the lower limit of the state's eligibility improper payment rate (excluding underpayments) exceeds the 3 percent threshold. For example, a state has a Medicaid eligibility improper payment rate of 10 percent. The lower limit of the 95 percent confidence interval is 5 percent and the upper limit is 15 percent. Thus, the lower limit exceeds the 3 percent threshold by 2 percentage points (the 5 percent lower limit less the 3 percent threshold is 2 percent). The state's FFP for Medicaid will then be reduced by 2 percent. The 2 percent reduction will be based on the total FFP received for the state's Medicaid program during the period spanning the state's PERM review year.

Comment: Commenters requested that CMS revise the proposed § 431.1010 to include authority to disallow only those expenditures that actually produced a cost to the federal government.

Response: As specified in § 431.972, the PERM claims universe includes payments which are eligible for FFP (or would have been if the claim had not been denied) through Title XIX (Medicaid) or Title XXI (CHIP). Therefore, all improper payments identified through PERM and included in improper payment rates used for calculation of payment reductions/disallowances would include FFP.

Comment: A few commenters stated that a state should only be required to return funds based on a calculation of excess FFP, and not for any underclaiming of FFP.

Response: While the occurrence of eligibility underpayments is expected to be extremely rare, we agree and will revise the regulatory text to remove underpayments from any payment reduction/disallowance calculations. We are revising § 431.1010(a)(2) to specify that, after the state's eligibility improper rate has been established for each PERM review period, we will compute the amount of the disallowance, removing any underpayments due to eligibility errors, and adjust the FFP payable to each state.

Comment: One commenter requested that CMS clarify if FFP will be reduced or disallowed at a program and/or waiver level only. The commenter stated that disallowances tied to Medicaid and/or CHIP in total will inappropriately reduce or disallow FFP and will put beneficiaries at risk for not receiving medically necessary services.

Response: For each state, along with the improper payment rate, we calculate a 95 percent confidence interval, which has a lower limit and an upper limit. Under the proposed rule, if a state's Medicaid and/or CHIP eligibility improper payment rate is above the 3 percent allowable threshold per section 1903(u) of the Act, and the state fails to demonstrate a good faith effort in reducing its eligibility improper payment rate, then further action will be taken. Using the lower limit of the state's eligibility improper payment rate (excluding underpayments), the state's FFP for the Medicaid program and/or CHIP will be reduced by the amount that the lower limit of the state's program-specific eligibility improper payment rate exceeds the 3 percent threshold. Payment reductions/disallowances will only be pursued after each state has been measured twice under this regulation. This provision affords states with the ability to demonstrate a good faith effort as defined in this regulation.

Comment: One commenter requested clarification for whether payment reductions and disallowances would also be applied to the years between PERM cycles for a state whose last PERM eligibility improper payment rate was above the 3 percent threshold, and that state failed to demonstrate a good faith effort.

Response: The disallowance of FFP for states whose PERM eligibility improper payment rate is over the 3 percent threshold and who fail to demonstrate a good faith effort applies to each state only in the state's PERM year. Although this rate remains frozen until the state's next PERM eligibility improper payment rate, the disallowance will not be extended to the 2 years between a state's PERM years. For clarification purposes, we have added language to § 431.1010(a)(2) to specifically state the period of payment reduction/disallowance.

Comment: One commenter requested that CMS strengthen the requirement for what it means for states to demonstrate a good faith effort to obtain a waiver from payment reductions/disallowances, should a state exceed the 3 percent threshold. The commenter recommended that a state should have to show a reduction in the eligibility improper payment rate from the first PERM year to the second PERM year in order to be granted a good faith waiver.

Response: Factors impacting PERM eligibility improper payment rates are complex and vary from year to year. Thus, even though a state's improper payment rate does not decrease between PERM years, it does not mean the same

errors and/or deficiencies exist, or necessarily mean that the state did not implement effective corrective actions. We continue to believe that the proposed requirements of a state's participation in the MEQC pilot program in conformity with §§ 431.800 through 431.820 and its implementation of PERM CAPs in accordance with § 431.992 are essential elements to the showing of a state's good faith effort.

Comment: One commenter suggested CMS clarify that the good faith waiver is limited to one PERM cycle and will not be extended.

Response: In the event that a state does receive a good faith waiver, it will not be extended beyond the PERM year in which it was received. Any state whose PERM eligibility improper payment rate is above the 3 percent threshold for consecutive cycles must meet the good faith waiver requirements for each cycle.

Comment: A commenter requested that CMS clarify additional exemptions states can meet in addition to the MEQC pilots that would allow states to be eligible for a good faith waiver.

Response: The good faith waiver requirements are outlined at § 431.1010(b)(2). There are no additional exemptions. We will grant a good faith waiver only if a state both participates in the MEQC pilot program and implements PERM CAPs.

We also received many comments supporting our proposal to require PERM to meet section 1903(u) of the Act in states PERM years. Therefore, in response to the comments received, we are adding language at § 431.1010(a)(2) and (a)(3)(i) to exclude underpayments from any payment reduction/disallowance calculations. We also revised the definition of "disallowance" at § 431.958 and added clarification at § 431.1010(a)(2) to state that payment reduction/disallowance is only applicable to a state's PERM year. We are finalizing the remaining provisions as proposed.

III. Provisions of the Final Regulations

With the exception of the following provisions and other minor stylistic revisions, this final rule incorporates the provisions of the proposed rule. Those provisions of this final rule that differ from the proposed rule are as follows:

- In § 431.804, we are replacing the proposed definition of "deficiency" with the correct MEQC definition of "deficiency."
- At § 431.814(b)(1)(i), we are adding the requirement for states to provide the justification for the focus of the active case reviews.

- In § 431.958, we are revising the definitions of “corrective action,” “difference resolution,” “disallowance,” and changing the definition “error” to “payment error” as a result of issues raised by commenters.

- At § 431.992(a)(2), we are adding a requirement for states to provide an evaluation of whether actions states take to reduce eligibility errors will also avoid increases in improper denials.

- At § 431.998(d), we are updating the time allowances for states to request difference resolutions and appeals.

- At § 431.1010(a)(2), we are adding that payment reduction/disallowance calculations will not include underpayments, and that payment reductions/disallowances are only applicable to the state’s PERM year.

- At § 431.1010(a)(3)(i), we are adding that underpayments will be excluded from payment reduction/disallowance calculations.

IV. Collection of Information

Under the Paperwork Reduction Act of 1995 (PRA), we are required to publish a 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.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA 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 burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the

affected public, including the use of automated collection techniques.

The estimates in this collection of information were derived from feedback received from states during the PERM cycle. We solicited public comment on each of the required issues under section 3506(c)(2)(A) of the PRA for the following information collection requirements (ICRs).

Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics’ May 2014 National Industry-Specific Occupational Employment and Wage Estimates for State Government (NAICS 999200) (http://www.bls.gov/oes/current/naics4_999200.htm#13-0000). In this regard, Table 1 presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 1—(SUMMARY OF 2014 BLS STATE GOVERNMENT WAGE ESTIMATES)

Occupation title	Occupation code	Mean hourly wage (\$/hr)	Fringe benefit (\$/hr)	Adjusted hourly wage (\$/hr)
Claims Adjusters, Appraisers, Examiners, and Investigators	13–1031	27.60	27.60	55.20
Medical Secretaries	43–6013	16.50	16.50	33.00

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

A. ICRs Regarding Review Procedures (§ 431.812)

Section 431.812 requires states to conduct one MEQC pilot during the 2 years between their designated PERM years. Revisions to § 431.812 requires that states must use the MEQC pilots to perform both active and negative case reviews, while providing states with some flexibility surrounding their active case review pilot. States will review a minimum total of 400 Medicaid and CHIP active cases, with at least 200 of the active cases being Medicaid cases. States will have the flexibility to determine the precise distribution of active cases (for example, states could sample 300 Medicaid cases and 100 CHIP cases), and states will describe the active sample distribution in the MEQC

pilot planning document at § 431.814. States will also, at a minimum, be required to review 200 Medicaid and 200 CHIP negative cases. Currently, under the PERM program, states are required to conduct approximately 200 negative case reviews for each the Medicaid program and CHIP. Therefore, a total minimum negative sample size of 400 (200 for each program) will be reviewed under the MEQC pilots.

Section 431.812 aligns with § 431.816 and outlines the case review completion deadlines and submission of reports. Additionally, § 431.820 is also considered to be a part of a state’s MEQC pilot reporting. Therefore, burden estimates are combined for the case reviews, the reporting of findings, including corrective actions. The time, effort, and costs listed in this section will be identical to the sections where § 431.816 and § 431.820 are described, but should not be considered additional or separate costs.

The ongoing burden associated with the requirements under § 431.812 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to a maximum of 34 total respondents each PERM off-year) to perform the required number of eligibility case reviews as

mentioned above, and report on their findings and corrective actions.

We estimate that it will take 1,200 hours annually per state program to report on all case review findings (900 hours) and corrective actions (300 hours). This estimate assumes that states spend approximately 100 hours a month on the related activities (100 hours x 12 months = 1,200 hours) during the State’s MEQC reporting year. The total estimated annual burden is 40,800 hours (1,200 hours x 34 respondents), at a total estimated cost per respondent of \$66,240 (1,200 hours x (\$55.20/hour)) and a total estimated cost of \$2,252,160 ((\$66,240 per respondent) x 34 respondents) for all respondents. The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection request currently approved under control number 0938–0147.

B. ICRs Regarding Pilot Planning Document (§ 431.814)

Revised § 431.814 requires states to submit a MEQC Pilot Planning Document. The Pilot Planning Document must be approved by us as outlined in § 431.814 of this final rule and is critical to ensuring that the state will conduct a MEQC pilot that complies with our guidance. The Pilot

Planning Document submitted by the state would include details surrounding how the state will perform both its active and negative case reviews.

The ongoing burden associated with the requirements under § 431.814 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP programs for 17 states equates to a maximum of 34 total respondents each PERM off-year) to develop, submit and gain CMS approval of its MEQC Pilot Planning Document.

We estimate that it will take 48 hours per MEQC pilot per state program to submit its Pilot Planning Document and gain approval under § 431.814. We have based the estimated 48 hours off of the pilot proposal process currently utilized in the FY 2014–2017 Medicaid and CHIP Eligibility Review Pilots, and have estimated the burden associated accordingly. The total estimated annual burden across all respondents is 1,632 hours ((48 hours/respondent) × 34 respondents). The total estimated cost per respondent is \$2,649.60 (48 hours × (\$55.20/hour)) and the total estimated annual cost across all respondents is \$90,086.40 ((\$2,649.60/respondent) × 34 respondents). As the MEQC program is currently suspended, and will be operationally different under this final rule, this estimate is not based on real time data. Once real time data is available, we will solicit information from the states and update our burden estimates accordingly.

The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection currently approved under control number 0938–0146.

C. ICRs Regarding Case Review Completion Deadlines and Submittal of Reports (§ 431.816)

Revised § 431.816 provides clarification surrounding the case review completion deadlines and submittal of reports. States would be required to report on all sampled cases in a CMS-specified format by August 1 following the end of the MEQC review period.

As mentioned above, § 431.816 aligns with § 431.812 and § 431.820, thus, the burden estimates are identical for these sections and should not be thought of as separate estimates or a duplication of effort. The ongoing burden associated with the requirements under § 431.816 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents each PERM off-year) to complete the required number of eligibility case reviews, and report on

their findings. Refer back to section IV.A., ICRs Regarding Review Procedures (§ 431.812), for the expanded burden estimate.

The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection currently approved under control number 0938–0147.

D. ICRs Regarding Corrective Action Under the MEQC Program (§ 431.820)

Under the current MEQC program, states are required to conduct corrective actions on all case errors, including technical deficiencies, found through the review. Corrective actions are critical to ensuring that states continually improve and refine their eligibility processes. Therefore, revisions to § 431.820 require states to implement corrective actions on any errors or deficiencies identified through the revised MEQC program as outlined under § 431.820.

We proposed that states report their corrective actions to us by August 1 following completion of the MEQC review period. The report would also include updates on previous corrective actions, including information regarding the status of corrective action implementation and an evaluation of those corrective actions.

The ongoing burden associated with the requirements under § 431.820 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents each PERM off-year) to develop and report its corrective actions in response to its MEQC pilot program findings. Refer back to section IV.A. of this final rule for the expanded burden estimate.

The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection currently approved under control number 0938–0147.

E. ICRs Regarding Information Submission and Systems Access Requirements (§ 431.970)

Currently, the PERM claims component requires state submission of Medicaid and CHIP FFS claims and managed care payments on a quarterly basis; and provider submission of medical records; state and provider submission responsibilities are defined under § 431.970. These claims and payments are rigorously reviewed by the federal statistical contractor. We are proposing to utilize this same claims universe to complete the PERM eligibility component. Previously, states had to pull a separate case universe for the PERM eligibility component. With

this proposed change, states would only be required to submit one universe to satisfy all components of PERM.

Additionally, states are required to collect and submit (with an estimate of 4 submissions) state policies. With this proposed change, states will still be required to collect and submit state policies surrounding FFS and managed care, but would now also have to submit all state eligibility policies. There would be an initial submission and quarterly updates. There are no proposed changes for the provider submission of medical records.

The ongoing burden associated with the requirements under § 431.970 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents each PERM year) to submit its claims universe, and collect and submit state policies, and the time and effort it would take providers to furnish medical record documentation.

We estimate that it will take 1,350 hours annually per state program to develop and submit its claims universe and state policies. The total estimated hours is broken down between the FFS, managed care, and eligibility components and is estimated at 900 hours for universe development and submission, and 450 hours for policy collection and submission. Per component it is estimated at 1,150 FFS hours, 100 managed care hours, and 100 eligibility hours for a total of 45,900 annual hours (1,350 hours × 34 respondents). The total estimated annual cost per respondent is \$74,520 (1,350 hours × (\$55.20/hour), and the total estimated annual cost across all respondents is \$2,533,680 ((\$74,520/respondent) × 34 respondents).

However, as a federal contractor has not previously conducted the eligibility component of PERM, the hours assessed related to the state burden associated with the revised eligibility component are not based on real time data, but rather based off information solicited from the states. The information received was from those states that participated in the PERM model eligibility pilots that were conducted by a federal contractor, but on a much smaller scale than that of PERM.

We estimate that it will take 2,824 hours annually per PERM cycle per program (Medicaid and CHIP) for providers to furnish medical record documentation to substantiate claim submission. The total estimated annual burden on providers is 5,648 hours (2,824 hours/program × 2 programs). We estimate the total cost to providers per program annually to be \$93,192 (2,824

hours × \$33.00/hour). The total estimated cost for providers is \$186,384 (\$93,192/program × 2 programs). These estimates are based on the average number of medical reviews conducted per PERM cycle and the average amount of time it takes for providers to comply with the medical record request. These estimates are for FFS claims only, as medical review is only completed on sampled FFS claims.

The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection currently approved under control numbers 0938–0974, 0938–0994, and 0938–1012.

F. ICRs Regarding Corrective Action Plan Under the PERM Program (§ 431.992)

Currently, under § 431.992, states are required to submit corrective action plans to address all improper payments and deficiencies found through the PERM review. Proposed revisions to § 431.992(a) clarify that states would be required to address all improper payments and deficiencies included in the state improper payment rate as defined at § 431.960(f)(1). Additional language was also added to § 431.992 to clarify the state responsibility to evaluate corrective actions from the previous PERM cycle at § 431.992(b)(4).

The ongoing burden associated with the requirements under § 431.992 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents per PERM cycle) to submit its corrective action plan.

We estimate that it will take 750 hours (250 hours for FFS, 250 hours for managed care and an additional 250 hours for eligibility), per PERM cycle

per state program to submit its corrective action plan for a total estimated annual burden of 25,500 hours ((750 hours/respondent) × 34 respondents). We estimate the total cost per respondent to be \$41,400 (750 hours × (\$55.20/hour)). The total estimated cost for all respondents is \$1,407,600 ((\$41,400/respondent) × 34 respondents).

However, as a federal contractor has not previously conducted the eligibility component of PERM, the hours assessed related to the state burden associated with the revised eligibility component are not based on real time data, but rather based off information solicited from the states. The information received was from those states that participated in the PERM model eligibility pilots which were conducted by a federal contractor, but on a much smaller scale than that of PERM.

The preceding requirements and burden estimates will be submitted to OMB as part of revisions to the information collections currently approved under control numbers 0938–0974, 0938–0994, and 0938–1012. Not to be confused with the burden set outlined above, the revised PERM PRA packages’ total burden would amount to: 34 annual respondents, 34 annual responses, and 750 hours per corrective action plan.

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

Currently, the difference resolution and appeals process used for the FFS and managed care components of the PERM program is well developed and has allowed us to adequately resolve disagreements between the RC and states. Revisions to § 431.998 now include the proposed eligibility changes for the difference resolution and appeals

process. Because we proposed to use an ERC to conduct the eligibility case reviews, we likewise proposed that the ERC conduct the eligibility difference resolution and appeals process, which would mirror how that process is conducted with respect to FFS claims and managed care payments.

The ongoing burden associated with the requirements under § 431.998 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents per PERM cycle) to review PERM findings and inform the federal contractor(s) of any additional information and/or dispute requests.

We estimate that it will take 1625 hours (500 hours for FFS, 475 hours for managed care and an additional 650 hours for eligibility) per PERM cycle per state program to review PERM findings and inform federal contractor(s) of any additional information or dispute requests for FFS, managed care, and eligibility components total estimated annual burden of 55,250 hours ((1,625 hours/respondent) × 34 respondents). We estimate the total cost per respondent to be \$89,700 (1,625 hours × (\$55.20/hour)). The total estimated cost for all respondents is \$3,049,800 ((\$89,700/respondent) × 34 respondents).

The preceding requirements and burden estimates will be submitted to OMB as revisions to the information collections currently approved under control numbers 0938–0974, 0938–0994, and 0938–1012. Not to be confused with the burden set outlined above, the revised PERM PRA packages’ total burden would amount to: 34 annual respondents, 34 annual responses, and 1,625 hours per PERM cycle.

TABLE 2—SUMMARY OF ANNUAL INFORMATION COLLECTION BURDEN ESTIMATES

Regulation section(s)	OCN	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Labor cost of reporting (\$)	Total cost (\$)
§ 431.812	0938–0147	34	34	1,200	40,800	\$66,240.00	\$2,252,160.00
§ 431.814	0938–0146	34	34	48	1,632	2,649.60	90,086.40
§ 431.816	0938–0147	34	*34	*1,200	*40,800	*66,240.00	*2,252,160.00
§ 431.820	0938–0147	34	*34	*1,200	*40,800	*66,240.00	*2,252,160.00
§ 431.970	0938–0974; 0938–0994; 0938–1012.	34	34	1,350	45,900	74,520.00	2,533,680.00
§ 431.970	Provider Submissions.	Varies	Varies	Varies	5,648	93,192.00	186,384.00
§ 431.992	0938–0974; 0938–0994; 0938–1012.	34	34	750	25,500	41,400.00	1,407,600.00
§ 431.998	0938–0974; 0938–0994; 0938–1012.	34	34	1,625	55,250	89,700.00	3,049,800.00

TABLE 2—SUMMARY OF ANNUAL INFORMATION COLLECTION BURDEN ESTIMATES—Continued

Regulation section(s)	OCN	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Labor cost of reporting (\$)	Total cost (\$)
Total	34	34	174,730	367,701.60	9,519,710.404

* Not included in totals, as these represent the combined estimated hours/cost for 3 sections as mentioned above. These numbers should only be counted once.

The following is a summary of the comments we received regarding our information collection requirements.

Comment: Two commenters requested that CMS revisit the PERM collection of information estimates, as both commenters stated they were vastly underestimated.

Response: We solicited information from the states prior to developing these estimates. We received several responses, and as a result averaged the information provided from the states regarding the hours spent on PERM activities. We acknowledged that there will be outliers that fall above and below these estimates; however, the estimates represent a national average of the time and costs for states to perform PERM activities based on the previous PERM ICR estimates, as well as the information received from states. We also acknowledged that, as a federal contractor has not previously conducted the eligibility component of PERM, the hours assessed related to the state burden associated with the revised eligibility component are not based on real time data, but, rather, based off of the information solicited from the states. The information received was from those states that participated in the PERM model eligibility pilots that were conducted by a federal contractor, but on a much smaller scale than that of PERM. We plan to update these estimates once real time data is available, and, also, as needed in the future to ensure an adequate representation of the national averages.

Comment: One commenter requested that CMS review the combined costs of MEQC activities.

Response: As the MEQC program is currently suspended, and will be operationally different under this final rule, this estimate is not based on real time data. Once real time data is available, we will solicit information from the states and update our burden estimates accordingly. These estimates were based on information we solicited from the states regarding the time spent performing activities associated with the FY 2014–2017 Medicaid and CHIP Eligibility Review Pilots. We received several responses and this information

was then averaged to obtain the estimates above.

Comment: One commenter stated she did not support the requirement for states to collect and submit all state eligibility policies, due to states having limited staff and resources.

Response: This requirement was developed to ensure the ERC was provided with the most up-to-date state eligibility policy information. We will implement a process which is intended to limit state burden; however, states are required to comply with the requirement.

As a result of the comments, we are finalizing the information collection requirements as proposed. However, upon review, one technical miscalculation was found and corrected in Table 2. The one technical miscalculation was due to human error, as the “Total” under the “Total Annual Burden (hours)” column was entered incorrectly. Addition of the numbers in the “Total Annual Burden (hours)” column was correct as published, but the number entered as the total in the “Total” field was incorrect. Also, we have clarified this information for easier reading, by separating out the “Provider Submission” estimates from the section it was under at time of the proposed rule’s publication.

V. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96 354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 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 Orders 12866 and 13563 direct 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). This final rule will make small changes to the administration of the existing MEQC and PERM programs. It would therefore have a relatively small economic impact; as a result, this final rule does not reach the \$100 million threshold and thus is neither an “economically significant” rule under E.O. 12866, nor a “major rule” under the Congressional Review Act.

The Regulatory Flexibility Act requires agencies to analyze options for regulatory relief of small entities, and to prepare a final regulatory flexibility analysis for final rules that would have a “significant economic impact on a substantial number of small entities.” For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. These entities may incur costs due to collecting and submitting medical records to support medical reviews, but we estimate that these costs will not be significantly changed under this final rule. Therefore, we have determined that this final 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 604 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. For the preceding reasons, we are not preparing an analysis for section 1102(b) of the Act because we have determined that this

final rule will not have a direct economic impact on the operations of a substantial number of small rural hospitals.

Please note, 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.

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 2017, that threshold is approximately \$148 million. For the preceding reasons, we have determined that this final rule does not mandate any spending that would approach the \$148 million threshold for state, local, or tribal governments, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues 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 final rule will shift minor costs and burden for conducting PERM eligibility reviews from states to the federal government and its contractors. However, these reductions would be largely offset by federal government savings in reduced payments to states in matching funds. The net effect of this regulation on state or local governments is minor.

Consistent with Executive Order 13771 (82 FR 9339, February 3, 2017), we have estimated the cost savings of this final rule for the PERM program to be \$8,387,860.80. This cost savings estimate is quantifiable for only the PERM program, includes both federal and state savings, and is attributable to reduced burden in the PERM program by shifting the eligibility review responsibility from the states to a federal contractor. While we believe this final rule would generate cost savings for the MEQC program as well, we are unable to quantify the cost savings. This rule is an E.O. 13771 deregulatory action.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the OMB.

List of Subjects

42 CFR Part 431

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

42 CFR Part 457

Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

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

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

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

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

- 2. Section 431.800 and the undesignated center heading preceding the section are revised to read as follows:

Medicaid Eligibility Quality Control (MEQC) Program

§ 431.800 Basis and scope.

This subpart establishes State requirements for the Medicaid Eligibility Quality Control (MEQC) Program designed to reduce erroneous expenditures by monitoring eligibility determinations and a claims processing assessment that monitors claims processing operations. MEQC will work in conjunction with the Payment Error Rate Measurement (PERM) Program established in subpart Q of this part. In years in which the State is required to participate in PERM, as stated in subpart Q of this part, it will only participate in the PERM program and will not be required to conduct a MEQC pilot. In the 2 years between PERM cycles, the State is required to conduct a MEQC pilot, as set forth in this subpart.

- 3. Section 431.804 is revised to read as follows:

§ 431.804 Definitions.

As used in this subpart—

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

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

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

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

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

Medicaid Eligibility Quality Control (MEQC) means a program designed to reduce erroneous expenditures by monitoring eligibility determinations and work in conjunction with the PERM program established in subpart Q of this part.

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

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

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

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

Payment Error Rate Measurement (PERM) Program means the program set forth at subpart Q of this part utilized to calculate a national improper payment rate for Medicaid and CHIP.

PERM year is the scheduled and designated year for a State to participate in, and be measured by, the PERM Program set forth at subpart Q of this part.

- 4. Section 431.806 is revised to read as follows:

§ 431.806 State requirements.

(a) *General requirements.* (1) In a State's PERM year, the PERM measurement will meet the requirements of section 1903(u) of the Act.

(2) In the 2 years between each State's PERM year, the State is required to conduct one MEQC pilot, which will span parts of both off years.

(i) The MEQC pilot review period will span 12 months of a calendar year, beginning the January 1 following the end of the State's PERM year through December 31.

(ii) The MEQC pilot planning document described in § 431.814 is due no later than the first November 1

following the end of the State's PERM year.

(iii) A State must submit its MEQC pilot findings and its plan for corrective action(s) by the August 1 following the end of its MEQC pilot review period.

(b) *PERM measurement.* Requirements for the State PERM review process are set forth in subpart Q of this part.

(c) *MEQC pilots.* MEQC pilot requirements are specified in §§ 431.812 through 431.820.

(d) *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 §§ 431.830 through 431.836.

■ 5. The undesignated center heading preceding § 431.810 is removed and § 431.810 is revised to read as follows:

§ 431.810 Basic elements of the Medicaid Eligibility Quality Control (MEQC) Program

(a) *General requirements.* The State must operate the MEQC pilot in accordance with this section and §§ 431.812 through 431.820, as well as other instructions established by CMS.

(b) *Review requirements.* The State must conduct reviews for the MEQC pilot in accordance with the requirements specified in § 431.812 and other instructions established by CMS.

(c) *Pilot planning requirements.* The State must develop a MEQC pilot planning proposal in accordance with requirements specified in § 431.814 and other instructions established by CMS.

(d) *Reporting requirements.* The State must report the finding of the MEQC pilots in accordance with the requirements specified in § 431.816 and other instructions established by CMS.

(e) *Corrective action requirements.* The State must conduct corrective actions based on the findings of the MEQC pilots in accordance with the requirements specified in § 431.820 and other instructions established by CMS.

■ 6. Section 431.812 is revised to read as follows:

§ 431.812 Review procedures.

(a) *General requirements.* Each State is required to conduct a MEQC pilot during the 2 years between required PERM cycles in accordance with the approved pilot planning document specified in § 431.814, as well as other instructions established by CMS. The agency and personnel responsible for the development, direction, implementation, and evaluation of the MEQC reviews and associated activities,

must be functionally and physically separate from the State agencies and personnel that are responsible for Medicaid and CHIP policy and operations, including eligibility determinations.

(b) *Active case reviews.* (1) The State must review all active cases selected from the universe of cases, as established in the State's approved MEQC pilot planning document, under § 431.814 to determine if the cases were eligible for services, as well as to identify deficiencies in processing subject to corrective actions.

(2) The State must select and review, at a minimum, 400 active cases in total from the Medicaid and CHIP universe.

(i) The State must review at least 200 Medicaid cases.

(ii) The State will identify in the pilot planning document at § 431.814 the sample size per program.

(iii) The State may sample more than 400 cases.

(3) The State may propose to focus the active case reviews on recent changes to eligibility policies and processes, areas where the state suspects vulnerabilities, or proven error prone areas.

(i) Unless otherwise directed by CMS, the State must propose its active case review approach in the pilot planning document described at § 431.814 or perform a comprehensive review.

(ii) When the State has a PERM eligibility improper payment rate that exceeds the 3 percent national standard for two consecutive PERM cycles, the State must follow CMS direction for its active case reviews. CMS guidance will be provided to any state meeting this criteria.

(c) *Negative case reviews.* (1) As established in the State's approved MEQC pilot planning document under § 431.814, the State must review negative cases selected from the State's universe of cases that are denied or terminated in the review month to determine if the denial, or termination, was correct, as well as to identify deficiencies in processing subject to corrective actions.

(2) The State must review, at a minimum, 200 negative cases from Medicaid and 200 negative cases from CHIP.

(i) The State may sample more than 200 cases from Medicaid and/or more than 200 cases from CHIP.

(ii) [Reserved]

(d) *Error definition.* (1) An active case error is an error resulting from the State's improper application of Federal rules and the State's documented policies and procedures that causes a beneficiary to be determined eligible when he or she is ineligible for

Medicaid or CHIP, causes a beneficiary to be determined eligible for the incorrect type of assistance, or when a determination did not occur timely or cannot be verified.

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

(i) Applications for Medicaid or CHIP that are improperly denied by the State.

(ii) Existing cases that are improperly terminated from Medicaid or CHIP by the State.

(e) *Active case payment reviews.* In accordance with instructions established by CMS, the State must also conduct payment reviews to identify payments for active case errors, as well as identify the individual's understated or overstated liability, and report payment findings as specified in § 431.816.

■ 7. Section 431.814 is revised to read as follows:

§ 431.814 Pilot planning document.

(a) *Plan approval.* For each MEQC pilot, the State must submit a MEQC pilot planning document that meets the requirements of this section to CMS for approval by the first November 1 following the end of the State's PERM year. The State must receive approval for a plan before the plan can be implemented.

(b) *Plan requirements.* The State must have an approved pilot planning document in effect for each MEQC pilot that must be in accordance with instructions established by CMS and that includes, at a minimum, the following for—

(1) *Active case reviews.* (i) Focus of the active case reviews in accordance with § 431.812(b)(3) and justification for focus.

(ii) Universe development process.

(iii) Sample size per program.

(iv) Sample selection procedure.

(v) Case review process.

(2) *Negative case reviews.* (i) Universe development process.

(ii) Sample size per program.

(iii) Sample selection procedure.

(iv) Case review process.

■ 8. Section 431.816 is revised to read as follows:

§ 431.816 Case review completion deadlines and submittal of reports.

(a) The State must complete case reviews and submit reports of findings to CMS as specified in paragraph (b) of this section in the form and at the time specified by CMS.

(b) In addition to the reporting requirements specified in § 431.814 relating to the MEQC pilot planning

document, the State must complete case reviews and submit reports of findings to CMS in accordance with paragraphs (b)(1) and (2) of this section.

(1) For all active and negative cases reviewed, the State must submit a detailed case-level report in a format provided by CMS.

(2) All case-level findings will be due by August 1 following the end of the MEQC review period.

■ 9. Section 431.818 is revised to read as follows:

§ 431.818 Access to records.

The State, upon written request, must submit to the HHS staff, or other designated entity, all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I of this chapter.

■ 10. Section 431.820 is revised to read as follows:

§ 431.820 Corrective action under the MEQC program.

The State must—

(a) Take action to correct any active or negative case errors, including deficiencies, found in the MEQC pilot sampled cases in accordance with instructions established by CMS;

(b) By the August 1 following the MEQC review period, submit to CMS a report that—

(1) Identifies the root cause and any trends found in the case review findings.

(2) Offers corrective actions for each unique error and deficiency finding based on the analysis provided in paragraph (b)(1) of this section.

(c) In the corrective action report, the State must provide updates on corrective actions reported for the previous MEQC pilot.

§ 431.822 [Removed]

■ 11. Section 431.822 is removed.

§§ 431.861—431.865 [Removed]

■ 12. The undesignated center heading “Federal Financial Participation” and §§ 431.861 through 431.865 are removed.

■ 13. Section 431.950 is revised to read as follows:

§ 431.950 Purpose.

This subpart requires States and providers to submit information and provide support to Federal contractors as necessary to enable the Secretary to produce national improper payment estimates for Medicaid and the Children’s Health Insurance Program (CHIP).

■ 14. Section 431.958 is amended by—

■ a. Removing the definitions of “Active case”, “Active fraud investigation”, and “Agency”.

■ b. Revising the definition of “Annual sample size”.

■ c. Adding a definition, in alphabetical order, for “Appeals”.

■ d. Removing the definitions of “Application”, “Case”, “Case error rate”, and “Case record”.

■ e. Adding definitions, in alphabetical order, for “Corrective action”, “Deficiency”, “Difference resolution”, “Disallowance”, “Eligibility Review Contractor (ERC)”, “Federal contractor”, “Federally Facilitated Exchange (FFE)”, “Federally Facilitated Exchange-Determination (FFE-D)”, “Federal financial participation”, “Finding”, and “Improper payment rate”.

■ f. Removing the definition of “Last action”.

■ g. Adding a definition, in alphabetical order, for “Lower limit”.

■ h. Removing the definition of “Negative case”.

■ i. Adding a definition, in alphabetical order, for “Payment error”.

■ j. Removing the definitions of “Payment error rate” and “Payment review”.

■ k. Adding definitions, in alphabetical order, for “PERM Review Period”, “Recoveries”, and “Review Contractor (RC)”.

■ l. Removing the definitions of “Review cycle” and “Review month”.

■ m. Revising the definition of “Review year”.

■ n. Removing the definitions of “Sample month” and “State agency”.

■ o. Adding a definition, in alphabetical order, for “State eligibility system”.

■ p. Revising the definition of “State error”.

■ q. Adding definitions, in alphabetical order, for “State payment system”, “State-specific sample size”, and “Statistical Contractor (SC)”.

■ r. Removing the definition of “Undetermined”.

The additions and revisions 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 that will be sampled for review in a given PERM cycle.

Appeals means a process that allows the State to dispute the PERM Review Contractor and Eligibility Review Contractor findings with CMS after the difference resolution process has been exhausted.

* * * * *

Corrective action means actions to be taken by the State to reduce errors or other vulnerabilities for the purpose of reducing improper payments in Medicaid and CHIP.

Deficiency means a finding in which a claim or payment had a medical, data processing, and/or eligibility error that did not result in federal and/or state improper payment.

Difference resolution means a process that allows the State to dispute the PERM Review Contractor and Eligibility Review Contractor findings directly with the contractor.

Disallowance means the percentage of Federal medical assistance funds the State is required to return to CMS in accordance with section 1903(u) of the Act.

* * * * *

Eligibility Review Contractor (ERC) means the CMS contractor responsible for conducting state eligibility reviews for the PERM Program.

Federal contractor means the ERC, RC, or SC which support CMS in executing the requirements of the PERM program.

Federally Facilitated Exchange (FFE) means the health insurance exchange established by the Federal government with responsibilities that include making Medicaid and CHIP determinations for states that delegate authority to the FFE.

Federally Facilitated Exchange—Determination (FFE-D) means cases determined by the FFE in states that have delegated the authority to make Medicaid/CHIP eligibility determinations to the FFE.

Federal financial participation means the Federal Government’s share of the State’s expenditures under the Medicaid program and CHIP.

Finding means errors and/or deficiencies identified through the medical, data processing, and eligibility reviews.

* * * * *

Improper payment rate means an annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

Lower limit means the lower bound of the 95-percent confidence interval for the State’s eligibility improper payment rate.

* * * * *

Payment error means any claim or payment where federal and/or state dollars were paid improperly based on

medical, data processing, and/or eligibility reviews.

* * * * *

PERM review period means the timeframe in which claims and eligibility are reviewed for national annual improper payment rate calculation purposes, July through June.

* * * * *

Recoveries mean those monies for which the State is responsible to pay back to CMS based on the identification of Federal improper payments.

Review Contractor (RC) means the CMS contractor responsible for conducting state data processing and medical record reviews for the PERM Program.

Review year means the year being analyzed for improper payments under the PERM Program.

* * * * *

State eligibility system means any system, within the State or with a state-delegated contractor, that is used by the state to determine Medicaid and/or CHIP eligibility and/or that maintains documentation related to Medicaid and/or CHIP eligibility determinations.

State error includes, but is not limited to, data processing errors and eligibility errors as described in § 431.960(b) and (d), as determined in accordance with documented State and Federal policies. State errors do not include the errors described in paragraph § 431.960(e)(2).

State payment system means any system within the State or with a state-delegated contractor that is used to adjudicate and pay Medicaid and/or CHIP FFS claims and/or managed care payments.

* * * * *

State-specific sample size means the sample size determined by CMS that is required from each individual State to support national improper payment rate precision requirements.

Statistical Contractor (SC) means the contractor responsible for collecting and sampling fee-for-service claims and managed care capitation payment data, as well as calculating Medicaid and CHIP state and national improper payment rates.

■ 15. Section 431.960 is revised to read as follows:

§ 431.960 Types of payment errors.

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

(b) *Data processing errors.* (1) A data processing error is an error resulting in

an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System, related systems, or outside sources of provider verification resulting in Federal and/or State improper payments.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with federal and state documented policies, is the dollar measure of the payment error.

(3) Data processing errors include, but are not limited to, the following:

- (i) Payment for duplicate items.
- (ii) Payment for non-covered services.
- (iii) Payment for fee-for-service claims for managed care services.

(iv) Payment for services that should have been paid by a third party but were inappropriately paid by Medicaid or CHIP.

- (v) Pricing errors.
- (vi) Logic edit errors.
- (vii) Data entry errors.
- (viii) Managed care rate cell errors.
- (ix) Managed care payment errors.

(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 medical record or other documentation supporting the service(s) claimed, Code of Federal Regulations that are applicable to conditions of payment, the State's written policies, and a comparison between the documentation and written policies and the information presented on the claim resulting in Federal and/or State improper payments.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with the applicable conditions of payment per 42 CFR parts 440 through 484, this part (431), and in accordance with the State's documented policies, is the dollar measure of the payment error.

(3) Medical review errors include, but are not limited to, the following:

- (i) Lack of documentation.
- (ii) Insufficient documentation.
- (iii) Procedure coding errors.
- (iv) Diagnosis coding errors.
- (v) Unbundling.
- (vi) Number of unit errors.
- (vii) Medically unnecessary services.
- (viii) Policy violations.
- (ix) Administrative errors.

(d) *Eligibility errors.* (1) An eligibility error is an error resulting in an

overpayment or underpayment that is determined from a review of a beneficiary's eligibility determination, in comparison to the documentation used to establish a beneficiary's eligibility and applicable federal and state regulations and policies, resulting in Federal and/or State improper payments.

(2) Eligibility errors include, but are not limited to, the following:

(i) Ineligible individual, but authorized as eligible when he or she received services.

(ii) Eligible individual for the program, but was ineligible for certain services he or she received.

(iii) Lacked or had insufficient documentation in his or her case record, in accordance with the State's documented policies and procedures, to make a definitive review decision of eligibility or ineligibility.

(iv) Was ineligible for managed care but enrolled in managed care.

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

(4) 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 in Federal law or guidance, or, if applicable, has the Secretary's approval.

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

(2) Eligibility errors resulting solely from determinations of Medicaid or CHIP eligibility delegated to, and made by, the Federally Facilitated Exchange will be included in the national improper payment rate.

(f) *Errors for purposes of determining the State improper payment rates.* The Medicaid and CHIP State improper payment rates include, but are not limited to, the errors described in paragraphs (b) through (d) of this section, and do not include the errors described in paragraph (e)(2) of this section.

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

■ 16. Section 431.970 is revised to read as follows:

§ 431.970 Information submission and systems access requirements.

(a) The State must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and CHIP, that include, but are not limited to—

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

(2) Upon request from CMS, provider contact information that has been verified by the State as current;

(3) All medical, eligibility, and other related policies in effect, and any quarterly policy updates;

(4) Current managed care contracts, rate information, and any quarterly updates applicable to the review year;

(5) Data processing systems manuals;

(6) Repricing information for claims that are determined during the review to have been improperly paid;

(7) Information on claims that were selected as part of the sample, but changed in substance after selection, for example, successful provider appeals;

(8) Adjustments made within 60 days of the adjudication dates for the original claims or line items, with sufficient information to indicate the nature of the adjustments and to match the adjustments to the original claims or line items;

(9) Case documentation to support the eligibility review, as requested by CMS;

(10) A corrective action plan for purposes of reducing erroneous payments in FFS, managed care, and eligibility; and

(11) Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining improper payment rates in Medicaid and CHIP.

(b) Providers must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and CHIP, which include but are not limited to Medicaid and CHIP beneficiary medical records, within 75 calendar days of the date the request is made by CMS. If CMS determines that the documentation is insufficient, providers must respond to the request for additional documentation within 14 calendar days of the date the request is made by CMS.

(c) The State must provide the Federal contractor(s) with access to all payment system(s) necessary to conduct the medical and data processing review, including the Medicaid Management Information System (MMIS), any systems that include beneficiary demographic and/or provider enrollment information, and any

document imaging systems that store paper claims.

(d) The State must provide the Federal contractor(s) with access to all eligibility system(s) necessary to conduct the eligibility review, including any eligibility systems of record, any electronic document management system(s) that house case file information, and systems that house the results of third party data matches.

■ 17. Section 431.972 is revised to read as follows:

§ 431.972 Claims sampling procedures.

(a) *General requirements.* The State will submit quarterly FFS claims and managed care payments, as identified in § 431.970(a), to allow federal contractors to conduct data processing, medical record, and eligibility reviews to meet the requirements of the PERM measurement.

(b) *Claims universe.* (1) The PERM claims universe includes payments that were originally paid (paid claims) and for which payment was requested but denied (denied claims) during the PERM review period, and for which there is FFP (or would have been if the claim had not been denied) through Title XIX (Medicaid) or Title XXI (CHIP).

(2) The State must establish controls to ensure FFS and managed care universes are accurate and complete, including comparing the FFS and managed care universes to the Form CMS-64 and Form CMS-21 as appropriate.

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

(1) *Precision and confidence levels.* The national annual sample size will be estimated to achieve at least a minimum National-level improper payment rate with a 90 percent confidence interval of plus or minus 2.5 percent of the total amount of all payments for Medicaid and CHIP.

(2) *State-specific sample sizes.* CMS will develop State-specific sample sizes for each State. CMS may take into consideration the following factors in determining each State's annual state-specific sample size for the current PERM cycle:

(i) State-level precision goals for the current PERM cycle;

(ii) The improper payment rate and precision of that improper payment rate from the State's previous PERM cycle;

(iii) The State's overall Medicaid and CHIP expenditures; and

(iv) Other relevant factors as determined by CMS.

§ 431.974 [Removed]

■ 18. Section 431.974 is removed.

§ 431.978 [Removed]

■ 19. Section 431.978 is removed.

§ 431.980 [Removed]

■ 20. Section 431.980 is removed.

§ 431.988 [Removed]

■ 21. Section 431.988 is removed.

■ 22. Section 431.992 is revised to read as follows:

§ 431.992 Corrective action plan.

(a) The State must develop a separate corrective action plan for Medicaid and CHIP for each improper payment rate measurement, designed to reduce improper payments in each program based on its analysis of the improper payment causes in the FFS, managed care, and eligibility components.

(1) The corrective action plan must address all errors that are included in the State improper payment rate defined at § 431.960(f)(1) and all deficiencies.

(2) For eligibility, the corrective action plan must include an evaluation of whether actions the State takes to reduce eligibility errors will also avoid increases in improper denials.

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

(1) *Error analysis.* The State must conduct analysis such as reviewing causes, characteristics, and frequency of errors that are associated with improper payments. The State must review the findings of the analysis to determine specific programmatic causes to which errors are attributed (for example, provider lack of understanding of the requirement to provide documentation), if any, and to identify root improper payment causes.

(2) *Corrective action planning.* The State must determine the corrective actions to be implemented that address the root improper payment causes and prevent that same improper payment from occurring again.

(3) *Implementation and monitoring.*

(i) The State must develop an implementation schedule for each corrective action and implement those actions in accordance with the schedule.

(ii) The implementation schedule must identify all of the following for each action:

(A) The specific corrective action.

(B) Status.

(C) Scheduled or actual implementation date.

(D) Key personnel responsible for each activity.

(E) A monitoring plan for monitoring the effectiveness of the action.

(4) *Evaluation.* The State must submit an evaluation of the corrective action plan from the previous measurement.

The State must evaluate the effectiveness of the corrective action(s) by assessing all of the following:

- (i) Improvements in operations.
- (ii) Efficiencies.
- (iii) Number of errors.
- (iv) Improper payments.
- (v) Ability to meet the PERM

improper payment rate targets assigned by CMS.

(c) The State must submit to CMS and implement the corrective action plan for the fiscal year it was reviewed no later than 90 calendar days after the date on which the State's Medicaid or CHIP improper payment rates are posted on the CMS contractor's Web site.

(d) The State must provide updates on corrective action plan implementation progress annually and upon request by CMS.

(e) In addition to paragraphs (a) through (d) of this section, each State that has an eligibility improper payment rates over the allowable threshold of 3 percent for consecutive PERM years, must submit updates on the status of corrective action implementation to CMS every other month. Status updates must include, but are not limited to the following:

(1) Details on any setbacks along with an alternate corrective action or workaround.

(2) Actual examples of how the corrective actions have led to improvements in operations, and explanations for how the improvements will lead to a reduction in the number of errors, as well as the State's next PERM eligibility improper payment rate.

(3) An overall summary on the status of corrective actions, planning, and implementation, which demonstrates how the corrective actions will provide the State with the ability to meet the 3 percent threshold.

■ 23. Section 431.998 is revised to read as follows:

§ 431.998 Difference resolution and appeal process.

(a) The State may file, in writing, a request with the relevant Federal contractor to resolve differences in the Federal contractor's findings based on medical, data processing, or eligibility reviews in Medicaid or CHIP.

(b) The State must file requests to resolve differences based on the medical, data processing, or eligibility reviews within 25 business days after the report of review findings is shared with the State.

(c) To file a difference resolution request, the State must be able to demonstrate all of the following:

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

(2) Provide the appropriate Federal contractor with valid evidence directly related to the finding(s) to support the State's position.

(d) For a finding in which the State and the Federal contractor cannot resolve the difference in findings, the State may appeal to CMS for final resolution by filing an appeal within 15 business days from the date the relevant Federal contractor's finding as a result of the difference resolution is shared with the State. There is no minimum dollar threshold required to appeal a difference in findings.

(e) To file an appeal request, the State must be able to demonstrate all of the following:

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

(2) Provide CMS with valid evidence directly related to the finding(s) to support the State's position.

(f) All differences, including those pending in CMS for final decision that are not overturned in time for improper payment rate calculation, will be considered as errors in the improper payment rate calculation in order to meet the reporting requirements of the IPIA.

■ 24. Section 431.1010 is added to subpart Q to read as follows:

§ 431.1010 Disallowance of Federal financial participation for erroneous State payments (for PERM review years ending after July 1, 2020).

(a) *Purpose.* (1) This section establishes rules and procedures for disallowing Federal financial participation (FFP) in erroneous medical assistance payments due to eligibility improper payment errors, as detected through the PERM program required under this subpart, in effect on and after July 1, 2020.

(2) After the State's eligibility improper rate has been established for each PERM review period, CMS will compute the amount of the disallowance, removing any underpayments due to eligibility errors, and adjust the FFP payable to each State. The disallowance or withholding is only applicable to the State's PERM year.

(3) CMS will compute the amount to be withheld or disallowed as follows:

(i) Subtract the 3 percent allowable threshold from the lower limit of the State's eligibility improper payment rate percentage excluding underpayments.

(ii) If the difference is greater than zero, the Federal medical assistance

funds for the period, are multiplied by that percentage. This product is the amount of the disallowance or withholding.

(b) *Notice to States and showing of good faith.* (1) If CMS is satisfied that the State did not meet the 3 percent allowable threshold despite a good faith effort, CMS will reduce the funds being disallowed in whole.

(2) CMS may find that a State did not meet the 3 percent allowable threshold despite a good faith effort if the State has taken the action it believed was needed to meet the threshold, but the threshold was not met. CMS will grant a good faith waiver only if the State both:

(i) Participates in the MEQC pilot program in accordance with §§ 431.800 through 431.820, and

(ii) Implements PERM CAPs in accordance with § 431.992.

(3) Each State that has an eligibility improper payment rate above the allowable threshold will be notified by CMS of the amount of the disallowance.

(c) *Disallowance subject to appeal.* If the State does not agree with a disallowance imposed under paragraph (e) of this section, it may appeal to the Departmental Appeals Board within 30 days from the date of the final disallowance notice from CMS. The regular procedures for an appeal of a disallowance will apply, including review by the Appeals Board under 45 CFR part 16.

PART 457—ALLOTMENTS AND GRANTS TO STATES

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

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

■ 26. Section 457.628(a) is revised to read as follows:

§ 457.628 Other applicable Federal regulations.

* * * * *

(a) HHS regulations in §§ 431.800 through 431.1010 of this chapter (related to the PERM and MEQC programs); §§ 433.312 through 433.322 of this chapter (related to Overpayments); § 433.38 of this chapter (Interest charge on disallowed claims of FFP); §§ 430.40 through 430.42 of this chapter (Deferral of claims for FFP and Disallowance of claims for FFP); § 430.48 of this chapter (Repayment of Federal funds by installments); §§ 433.50 through 433.74 of this chapter (sources of non-Federal share and Health Care-Related Taxes and Provider Related Donations); and § 447.207 of this chapter (Retention of Payments)

apply to State's CHIP programs in the same manner as they apply to State's Medicaid programs.

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Dated: April 4, 2017.

Seema Verma,
Administrator, Centers for Medicare & Medicaid Services.

Dated: June 16, 2017.

Thomas E. Price,
Secretary, Department of Health and Human Services.

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