Supporting Statement:
Payment Error Rate Measurement of Eligibility for Medicaid and the State Children's Health Insurance Program

A. Background

The Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and the State Children's Health Insurance Program (SCHIP). To comply with the IPIA, CMS will use a national contracting strategy in part to produce error rates for Medicaid and SCHIP fee-for-service and managed care improper payments. The federal contractor will review states on a rotational basis so that each state will be measured for improper payments, in each program, once and only once every three years.

Subsequent to the first publication, we determined that we will measure Medicaid and SCHIP in the same state. Therefore, states will measure Medicaid and SCHIP eligibility in the same year measured for fee-for-service and managed care. We believe this approach will advantage states through economies of scale (e.g. administrative ease and shared staffing for both programs reviews). We also determined that interim case completion timeframes and reporting are critical to the integrity of the reviews and to keep the reviews on schedule to produce a timely error rate. Lastly, the sample sizes were increased slightly in order to produce an equal sample size per strata each month. This supporting statement reflects those changes.

As outlined in the October 5, 2005 interim final rule, CMS convened an eligibility workgroup comprised of the Department of Health and Human Services, the Office of Management and Budget (OMB) and representatives from two states. The Office of Inspector General (OIG) participated in an advisory capacity. The workgroup was charged to make recommendations for measuring Medicaid and SCHIP improper payments based on eligibility errors within the confines of current statute, with minimal impact on states' resources and considering public comments on the August 27, 2004 proposed rule and the October 5, 2005 interim final rule. Based on the eligibility workgroup's recommendations and public comments, we developed an eligibility review methodology that we expect will provide consistency in the reviews of active (i.e., beneficiaries receiving Medicaid or SCHIP) and negative cases (i.e., beneficiaries whose benefits were denied or

terminated) as well as achieve the required confidence and precision at the national level.

We indicated in the proposed rule and the interim final rule that states would be expected to take some part in the eligibility reviews. We determined that states shall:

- Measure eligibility in the same year the states are selected for Medicaid and SCHIP FFS and managed care measurements;
- Submit a sampling plan;
- Select monthly samples;
- Submit monthly sample lists of those cases randomly selected for review;
- Conduct the eligibility and payment reviews;
- Report individual review and payment findings;
- Compute and report summary findings to CMS including the states' eligibility payment and case error rates for active cases, case error rate for negative cases and number and percentage of undetermined cases (i.e., cases where eligibility could not be verified); and
- Provide analysis of the findings and proposed actions in a corrective action plan.

The programs selected for review will submit an initial eligibility sampling plan to CMS for approval 60 days prior to the fiscal year being reviewed. (States will submit the sampling plans by November 15, 2006, for the FY 2007 review year). The sampling plan should be developed to produce an error rate that meets a 95 percent confidence interval (using the mid-point of the confidence level) with +/- three percent precision. Once the sampling plan is approved, it will serve as the basic plan and the state will only resubmit the sampling plan if it makes changes in future years. If the plan remains unchanged from the previous review year, States will notify CMS it is using the same plan.

These states also will submit monthly sample selection lists to CMS. States will select monthly samples and conduct the reviews using a CMS standardized review methodology. States shall report the review findings within 150 days of the sample month and report the payment review findings within 60 days of initial claims collection. Using a standard formula, states will then calculate and report to CMS, state-specific eligibility error rates for Medicaid and SCHIP based on the review results. The federal contractor will calculate national eligibility error rates for Medicaid and SCHIP based on the states' error rates.

B. Justification

1. <u>Need and Legal Basis</u>

The collection of information is necessary for CMS to produce national error rates for Medicaid and SCHIP as required by Public Law 107-300, the IPIA of 2002. In addition, Medicaid statute at section 1902(a)(6) of the Act and SCHIP statute at section 2107 (b)(1) of the Act require States to provide information that the Secretary finds necessary for the administration, evaluation, and verification of the State's program.

2. Information Users

The information collected from the states selected for review will be used by CMS to ensure states use a statistically sound sampling methodology, to ensure the states complete reviews on all cases sampled, and will be used by the federal contractor to calculate national Medicaid and SCHIP eligibility error rates.

3. Use of Information Technology

This information collection involves the use of electronic submission of information to the extent that states have the technological capability. CMS will not require states to provide information electronically if they do not have secure systems in place to do so. The error rate report form will require a signature and CMS will accept electronic signatures if available. The percentage of information expected not to be received electronically is less than one percent.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source for SCHIP. This information collection request does, to a certain extent, duplicate Medicaid eligibility reviews required under the Medicaid Eligibility Quality Control (MEQC)program under section 1903 (u) of the Social Security Act. We proposed the option to use the MEQC reviews to satisfy the PERM requirements in the first publication of this information request. We also considered the option to use the PERM reviews to satisfy the MEQC requirements. However, the PERM program is intended to fulfill the requirements of IPIA and is not intended to supplant, enhance or change other program integrity activities in which the States are currently engaged. We are considering methods to minimize duplication of efforts regarding the eligibility reviews. 5. Small Businesses

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

6. Less Frequent Collection

Failure to acquire this information will prevent CMS from effectively collecting state-specific eligibility payment error rates on which to base national eligibility error rates for Medicaid and SCHIP. Consequently, CMS will not be able to produce these error rates and will be out of compliance with IPIA requirements and subsequent OMB guidance.

7. Special Circumstances

CMS does not anticipate that states would be required to submit information more often than monthly in the year the states are reviewed (once every three years per program). For Medicaid and SCHIP, states will provide a sampling plan in the beginning of the year of selection, monthly selection lists at the beginning of each month, detailed and summary eligibility and payment findings on the cases sampled, error rates and a corrective action plan.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice for this information collection request published on May 26, 2006.

9. Payments/Gifts to Respondents

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

10. Confidentiality

Confidentiality has been assured in accordance with Section 1902(a) (7) of the Social Security Act.

11. Sensitive Questions

No questions of a sensitive nature are asked.

12. Burden Estimate (Total Hours & Wages)

The number of respondents is estimated to be 34 programs (17 Medicaid and 17 SCHIP). The annualized number of hours estimated that may be required to respond to requests for information equals 15,755 hours (hours per state, per program).

CMS recognizes there are other costs associated with this measurement, other than labor. These include overhead costs such as the cost to provide fringe benefits to employees, necessary supplies to complete reviews (e.g., mailing cases and verification requests, travel for possible interviews), training and manual development. These costs will vary from state to state depending on many variables including the type of program integrity practices in place, salaries and pricing. CMS included the FY 2006 CMS fringe rate (23.77 percent) and overhead rate (23 percent) as a reasonable cost estimate per

state in the hourly burden estimates for a total computable eligibility review cost per state, per program. The GS-12 was determined to be the estimated level of knowledge, skills and abilities to perform this work. The GS-12, step one hourly rate of pay, $26.53, was therefore multiplied by the CMS 23.77 percent fringe rate and 23 percent overhead rate. This totaled a fully loaded rate of $40.39. 15,755 hours x $40.39 per hour = $636,344.45 per state per program.

Each year, 17 states will participate in both the Medicaid error rate measurement and the SCHIP error rate measurement. Therefore, estimates were calculated for 34 responses to each request for information.

It is estimated that each state will spend up to 15,755 hours of time annually (when selected), per program, to support this collection of information. The state will provide the following information, per program:

1. A sampling plan, for CMS approval, based upon the universes of beneficiaries in the program and persons whose benefits were denied or terminated. States would only resubmit the sampling plan when changes are made (responding once per year @ 1,000 hours per program);
2. Monthly sample lists detailing the active and negative cases selected for review that month(responding 12 times per year @ 100 hours in each response or 1,200 hours per program);
3. Review findings on each case following the eligibility and payment reviews (responding to each of the approximately 708 sampled cases, i.e., approximately 504 active cases and 204 negative cases for a total estimated number of hours 10,055 hours per program) in order to prepare findings, including an error rate, reviews must be completed and the burden here is inclusive of all of the associated review activities (more detail below).
4. Report individual review findings within 150 days of the end of the sample month (responding 12 times per year @ 100 hours in each response or 1,200 hours per program);
5. Report individual payment findings 60 days after initiating the claims collection (responding 12 times per year @ 100 hours in each response or 1,200 hours per program);
6. Summary of eligibility and payment review findings, including an error rate (100 hours); and
7. A corrective action report for purposes of reducing the payment error rate in eligibility (responding once at up to 1,000 hours per state).

Sample Size Development

This measurement will be a case based sample with approximately 504 active cases and 204 negative cases, per program. Active case means a beneficiary who is enrolled in the Medicaid or SCHIP program in the month that the case is sampled. Negative case means a beneficiary who has completed an application for benefits and is denied or whose program benefits were terminated based on the state agency's completed redetermination.

These 708 cases will be sampled over the period of one fiscal year. The approximately 504 active cases will be further stratified into three equal strata (estimated at 168 cases each). The Medicaid active universe consists of all active Medicaid cases funded through Title XIX for the sample month. Cases for which the Social Security Administration, under a section 1634 agreement with a state, determines Medicaid eligibility for Supplemental Security Income recipients, are excluded from the Medicaid universe. All foster care and adoption cases under Title IV-E of the Act and cases under active beneficiary fraud are excluded from the Medicaid universe in all states.

The SCHIP active universe consists of all active SCHIP cases funded through Title XXI for the sample month and will also be stratified into three strata. Other than active beneficiary fraud cases, there are no SCHIP cases excluded from the SCHIP universe. The negative case samples for both programs will not be stratified.

The States will report both payment and case error rates for the active case reviews, a case error rate for the negative case reviews and the number and percent of cases and amount of payments where eligibility is undetermined. Given these parameters and that states' sampling plans must estimate a sample size to achieve an error rate at +/- three percent precision and 95 percent confidence (using the mid-point of the confidence interval); we anticipate that sampling plans will take up to 1,000 hours per state, per program.

Case Reviews

Based on the PAM Year 2 cost and efficiency study, we estimated it took an average of 12.4 hours to complete a case review. Except for one state participant, PAM Year 2 states conducted full eligibility reviews.

In the PERM measurement, active cases are divided into three strata: stratum 1 is completed applications for the sample month, stratum 2 is completed redeterminations for the sample month and

stratum three is all other active cases for the sample month. We believe that strata 1, 2 and negative case reviews will take a bit less time due to the ease of reviewing a recent state action on the case and strata three will take a bit more time due to varying timeframes when eligibility is reviewed, i.e., either when the last state action occurred or the sample month if the last action occurred prior to 12 months from the sample month. We estimated that 540 cases (204 negative, 168 stratum 1 active cases, and 168 stratum 2 active cases) will take 10 hours to complete the eligibility review and 168 (Stratum three) case reviews will take 15 hours to complete the eligibility review for a total of 7,920 hours for reviews.

We included an additional 2,135 hours to the 7,920 case review estimated hours (for a total of 10,055 hours) for supporting functions like training, supervision, quality assurance and creation of review tools, etc. Therefore, the 10,055 hours represents the burden to complete review findings to show the disposition of each case selected for review and includes all of the review supporting functions. CMS will use the detailed findings to compare to the monthly sample lists to determine that the state completed its reviews of the selected cases.

The following assumptions were used:

- The estimated number of programs needed to produce a national eligibility error rate with the confidence and precision to meet the IPIA requirements is 34 annually; 17 for Medicaid and 17 for SCHIP;
- The estimated number of cases needed from each state to produce a state specific eligibility error rate with the confidence and precision needed to have a national rate meet IPIA standards is estimated to be 504 per program;
- The 504 active cases per program are going to be equally stratified on a monthly basis in three (3) strata: 1) applications approved, (2) cases where eligibility was redetermined, (3) all other active cases. The 204 negative cases per program are not stratified;
- The 708 cases will be sampled over a full fiscal year;
- Review eligibility as of the last action the State took unless, for stratum three cases, that action was more than 12 months from the sample month. If so, review eligibility as of the sample month;
- Attach payments for services received:
    i. In the review month or the first 30 days of eligibility (according to state policy on full month or date specific eligibility coverage) for cases in strata one and two, and

ii. Within the sample month for cases in strata three;

- Review payments and verify whether the payments were made appropriately based on the eligibility review findings. The payment review may include determining if the beneficiary met his/her liability amount or cost of institutional care.
- Programs will calculate state-specific case error rate percentages, payment error rate percentages, and erroneous payment amounts for active cases;
- Programs will identify the number and percent of cases and payment amounts for undetermined cases (cases where eligibility could not be verified);
- Programs will calculate State-specific case error rate percentages for negative cases;
- Programs will exclude from the universe or the sample (if these cases can not be excluded from the universe), cases under active beneficiary fraud investigation; and
- Programs will conduct reviews in accordance with the state's eligibility policies that are in effect as of the month eligibility is being verified.

13. Capital Cost

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

14. Cost to the Federal Government

There are no additional costs.

15. Changes to Burden

This is a new requirement.

16. Publication/Tabulation Dates

States selected for the FY 2007 measurement will submit the Medicaid and SCHIP sampling plan by November 15, 2006. The states will also sample the 708 case reviews over a nine month period beginning with January 2007. For FY 2007 and beyond, States will report sample lists on the 15th of the month following the sample month. The detailed case review findings for 100 percent of cases reviewed in a sample month are due 150 days from the end of the sample month. Claims collection will begin in the fifth month following the sample month and will be reported within 60 days of the first day of the month in which the claims collection process begins. The final summary report and error rates are due July 1, 2008. The calculated national program error rates for both Medicaid and SCHIP will be published annually in the Performance and Accountability Report (PAR).

17. Expiration Date

This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement
There are no exceptions to the certification form.

C. Collections of Information Employing Statistical Methods

1. The universe for this project is the 50 states' and the District of Columbia's Medicaid and SCHIP programs.

The potential respondent universe is 17 unique programs (17 Medicaid and 17 SCHIP). We estimate that approximately 504 active cases will be randomly selected for review by each of the 17 states in each program to achieve a state specific, program specific eligibility payment error rate. These results will be used to calculate a national eligibility component error rate. We estimate states will randomly select 204 denied and terminated cases for the negative case reviews.

The anticipated response rate is 100 percent due to the statutory requirements at section 1902(a) (6) of the Act and section 2107(b) (1) of the Act that require states to provide information necessary for the Secretary to monitor program performance.

2. In the first year of each state's eligibility measurement, we determined a case sample size of 504 active and 204 negative (per state using an assumed error rate of 5 percent). In subsequent years, the actual sample size for each state will be estimated to achieve a 95 percent confidence level (using the mid-point of the confidence interval) within three percent precision.

In order to meet the requirements of IPIA, all selected states must participate.

3. We will depend on states to provide reliable data. The states are reporting findings monthly and on an annual basis for the year selected for review (once every three years).

4. Not applicable.

5. The Lewin Group was consulted on the statistical methodology of this project.