STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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November 3, 2005

NOV - 3 2005

Christine Jones and Janet E. Reichert
Centers for Medicare and Medicaid Services
Department of Health and Social Services
Attention: CMS-6026-IFC, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicaid and SCHIP Payment Error Rate Measurement (PERM)
Interim Final Rule

Dear Ms. Jones and Reichert;

The State of Alaska, Department of Health and Social Services, hereby submits comments and recommendations on the interim final rule on the Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement (PERM) that was published in the Federal Register on October 5, 2005 (70 FR 58260). The interim rule sets forth the state requirements for the PERM program. Pursuant to the rule, a Federal contractor selected by the Centers for Medicare and Medicaid Services (CMS) will conduct both the medical and data processing review in order to determine a "state-specific" payment error rate.

The interim rule estimates that only 1,630 hours per state per program (Medicaid and SCHIP) are needed "to collect" and "provide" to the Federal contractor the required information. This estimate substantially underestimates the amount of resources that will be needed to comply with the proposed rule for three reasons. First, experience with the PERM Pilot Project shows that these tasks will consume more hours. Second, the states will be forced to do more than just collect information and data for the Federal contractor if they wish to have an accurate payment error rate. Third, the estimate totally ignores the resources that will be needed to develop, submit, implement, monitor and evaluate the required corrective action plans.

Pursuant to the proposed rule, state staff is required to send to the Federal contractor a substantial amount of data such as annual expenditures, quarterly stratified claims data and medical policies that include the following: "statutes, regulations, individual Medicaid Provider Manual, Administrative Directives as well as other

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information that the contractor may need to determine errors in the medical reviews." Experience with the PERM Pilot Project indicates that this work will require more than 1,630 hours. Moreover, the rule proposes a substantially larger sample size, 200 to 300 sample claims per quarter. In contrast, the Pilot Project had a total of 300 sample claims.

The proposed rule does not take into account that each state will need to dedicate a substantial amount of personnel and resources to ensure that the payment error rate is accurate. Specifically, because the reviews will be conducted by a Federal contractor, state staff will need to continuously guide and explain to the contractor their claims and data processing system. Claims and data processing is complex and each state processes its claims in a different manner. In addition, each state has different regulations, policies and administrative directives pertaining to both medical and claims reviews. Accordingly, it will be difficult for a Federal contractor to become proficient in evaluating how claims are processed and reviewed in all 50 states without consistent guidance from the states.

The interim rule assumes the Federal contractor will have little difficulty obtaining medical documentation directly from providers. However, in our and other states' experience, obtaining medical records was one of the most difficult and time-consuming tasks. Numerous and time-consuming follow-up activities were conducted to obtain medical records from providers. It is questionable whether the Federal contractor will be as diligent and persistent in obtaining records and documentation. Again, states will need to commit significant resources to assist the Federal contractor in obtaining the required records and documentation in order to minimize payment error rates. Pursuant to the most recent CMS Pilot Project guidance, the non-receipt of medical records within the 90-day timeframe constituted an overpayment error.

The Federal contractor has an incentive to quickly complete the reviews because it will be compensated on a flat fee basis per review. In contrast, the states have an incentive to ensure that the payment error rate is accurate and not rush the reviews at the expense of incurring a greater error rate. It is the states that will be required to pay back any overpayments and undertake all of the activities pertaining to the corrective action plans that will be required because of overpayments that are identified by the contractor. Thus, in order to minimize inaccurate payment error rates, each of the states will need to become a contract manager in order to assist the Federal contractor unless they are indifferent to the possible outcome of the reviews. The proposed rule does not acknowledge this reality and consequently does not estimate the amount of resources that will be required for this significant task. It is requested that the rule be amended to consider the resources that will be required for this task.

The estimated number of hours to fulfill the requirements of the PERM program does not include the resources that will be required to develop, submit, implement, and monitor, and evaluate the corrective action plans. The proposed rule requires that each reviewed state submit a corrective action plan to CMS. There are many unanswered questions concerning these plans. Specifically, what is required in these plans and how

will they be monitored and evaluated? Thus, at the present time, it is impossible to determine the costs and resources that will be needed to comply with this requirement.

In addition to substantially underestimating the resources that states will be needed to comply with the PERM requirements and ensure an accurate payment error rate, the rule does not address several issues that will significantly affect the states. These issues are discussed below.

The proposed rule does not specifically address whether the states will have an opportunity to review the findings of the contractor before they are finalized. This is important because the state may have additional information or provide clarification that would eliminate an erroneous payment finding. If the process is implemented as described, it is critical that states be able to challenge and explain to the contractor why a finding is not an error. Without any ability to challenge, the result will be incorrect error rates and corrective action plans leading to no real improvements. To avoid this, it is recommended that the Federal contractor be required to work closely with state staff while the reviews are conducted.

As previously mentioned, obtaining records and documentation from providers can be problematic and cause an inaccurate payment error rate. Accordingly, it would be helpful if the states were notified immediately of the claims chosen for audit and the affected providers. States should also be allowed to assist and coordinate closely with the Federal contractor. This will enable state staff to assist providers in gathering and submitting complete medical records and other documentation. Incomplete records and documentation has a major impact on the review of claims and the calculation of the payment error rate.

In order to effectively conduct the reviews, the Federal contractor will need to have access to MMIS and other databases that the states utilize to process and review their claims. Obtaining this access will raise security issues. On the other hand, if state staff downloads the information from these databases for the contractor, this will impose an additional and significant burden on state staff. The proposed rule is silent on these issues.

To minimize confusion, it is recommended that each state be allowed to designate a liaison contact for the Federal contractor. This will facilitate communication between state staff and the contractor.

As previously mentioned, the proposed rule does not contain sufficient information in order to evaluate with accuracy the requirements of preparing, submitting, implementing, monitoring and evaluating corrective action plans. To avoid unnecessary waste of resources by the states, it is requested that CMS issue guidelines that are more specific and distribute a model corrective action plan to the states. The rule should also be amended to acknowledge and include an estimate on the activities pertaining to the development, submission, implementation, monitoring and evaluation of the corrective action plans.

The interim rule does not provide advance notice to the states of whether they are selected for the audit. Because of the usual budgetary and administrative constraints faced by all states, it is requested that CMS publish in advance its review schedule so that the states will know in what year their programs will be subject to audit. With notice, states can request from their legislature the additional substantial resources that will be needed to comply with the PERM requirements. The states can also engage in provider education to increase future compliance with the PERM audit requirements.

In the interim rule that was recently published, CMS summarily dismissed over half of the comments, concerns and requests for clarification submitted by the states pertaining to the review procedures. CMS responded by stating that the comments were "no longer relevant since States will not be conducting" the medical or data processing reviews. However, although state staff will not be conducting the reviews, clear guidelines will enhance state and provider understanding. This in turn will improve cooperation, compliance, quality and accuracy. Equally important is the fact that the states need to understand the processes, standards and requirements in order to develop and implement effective corrective action plans that will address the payment errors identified in the reviews. Thus, we seek to understand thoroughly the reviews and have the following specific comments concerning the reviews.

During the PERM Pilot Project some of the providers did not understand the relationship between HIPAA, the state and CMS. This confusion will only worsen with the addition of a Federal contractor. Accordingly, it is recommended that the records request letter clearly set forth the relationships, the obligation to provide records without compensation and that HIPAA explicitly allow this type of collection and audit by the Federal contractor. In addition, it is recommended that states be allowed to add state-specific authorities that are usually cited in their letter requesting records. To enhance accuracy and quality assurance, each state should have an opportunity to review and comment on the Federal contractor's records request letter before it is sent to providers.

There has been some confusion as to what the medical review encompasses. Previously published rules and initial CMS guidelines referred to a "medical necessity" review. In reality, the addendums and guidelines indicate that the medical review goes beyond the determination of whether a service was medically necessary e.g., reviewing unbundling, the accuracy of procedure and diagnosis coding, and policy related to the claim. The rule, guidelines and any relevant correspondence should explicitly state that the medical review is in fact a comprehensive review that includes a determination of whether the documentation is adequate.

It would also be helpful if the CMS guidelines clearly explain the difference between a medical necessity review and a comprehensive medical review, including defining the components of each type of review. Related to this issue is providing more guidance on how a claim line versus an entire claim will be reviewed. For example, if there is adequate documentation for the specific claim line but insufficient for the entire claim, is there an erroneous payment?

During the most recent PERM Pilot Project, the medical review guidelines requested providers to submit prior authorizations "if applicable." This confused most providers and documentation regarding prior authorizations was not submitted. Thus, it is recommended that the words, "if applicable" be omitted from any issued guidelines pertaining to prior authorizations. In addition, it is requested that CMS clearly state what documentation regarding the request for prior authorizations must be in the patient's file and when this documentation must be reviewed as part of the medical review.

The addendums provided by CMS for each provider type was very useful. However, it is suggested that a more complete and specific addendum be provided for the personal care service providers.

Finally, the guidance issued by CMS during the PERM Pilot Project was piece-meal and different versions were issued for the reviews. It would assist the states if CMS would issue one comprehensive review manual and date both the manual and any revisions thereto.

In summary, the estimated amount of resources to comply with the PERM requirements should be examined again. The present estimated number of hours is based on only the "collection" and submission of information to the Federal contractor. However, in order to ensure an accurate payment error rate, the states will need to dedicate substantial resources to stay actively involved and work closely with the Federal contractor. As a practical matter, the states will become contract managers unless they are indifferent to the possible outcome of the reviews. The proposed rule does not acknowledge this reality and consequently does not provide an estimate of the amount of resources that will be required for this significant task. It is requested that the rule be amended to consider the resources that will be required for this task.

The proposed rule also does not take into account the resources that will be needed to comply with an important requirement of the PERM program, the development, submission, implementation, monitoring and evaluation of the corrective action plans. It is recommended that the rule be amended to consider the resources that will be required for this task.

To ensure accuracy and quality assurance, it is recommended that the states be provided with an opportunity to review the findings of the contractor before they are finalized. In addition, states should be allowed to assist and coordinate closely with the Federal contractor during the reviews. Additional guidance should be issued with regard to the corrective action plans.

As everyone knows, states are subject to budgetary and administrative constraints. Accordingly, advance notice of the CMS review schedule would assist states in dedicating the needed resources to comply with the PERM requirements.

Specific comments and suggestions were submitted with regard to the review processes. It is hoped that they will be considered by CMS and not summarily dismissed. Although the Federal contractor will be the entity responsible for conducting the reviews, it is important for the states and providers to understand the processes, standards and requirements of the PERM program. Transparency will enhance cooperation, compliance, quality and accuracy.

Your consideration of our comments and suggestions is appreciated. If you have any questions, please contact me at (907)-465-3030.

Sincerely,

Jerry Fuller
Medicaid Director
State of Alaska
Department of Health & Social Services

cc. Anthony Lombardo
Elizabeth Vazquez

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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

NOV - 3 2005

Department of Human Services
DIVISION OF HEALTH CARE QUALITY,
FINANCING AND PURCHASING
600 New London Avenue
Cranston, R.I. 02920

November 1, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC; Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

The Rhode Island Department of Human Services is pleased to submit these comments on the *Interim Final Rule* (IFR) published in the *Federal Register* on October 5, 2005 that would require States to provide information to the Centers for Medicare & Medicaid Services (CMS) in order for CMS to estimate improper payments in the Medicaid and State Children's Health Insurance Program (SCHIP) using the Payment Error Rate Measurement (PERM) methodology. This *Interim Final Rule* is a revision of the *Proposed Rule* published in the *Federal Register* on August 27, 2004 and modified on September 24, 2004, concerning which the Rhode Island Department of Human Services submitted timely comments.

For the record, the State of Rhode Island continues to support the requirements of the Improper Payments Information Act (IPIA) of 2002 (P.L. 107-300) to review and identify annually those programs and activities susceptible to significant erroneous payments, to estimate annually the amount of improper payments, to identify the causes for the improper payments and actions to correct the causes, and to report information to the Federal government. We appreciate that CMS acknowledged the response burden that the *Proposed Rule* would have placed upon the States, which would have differentially impacted smaller States like ours financially. Use of a national contractor and sampling State programs every three years should reduce the response burden considerably, but continues to cause concern about the amount of effort that the State will need to devote to assisting the federal contractor in order for the State to have confidence in the results. We believe, that the *Interim Final Rule,* to satisfy the requirements of IPIA, is still fraught with numerous problems and would, if implemented, still place an undue technical and financial burden on the State of Rhode Island, with the estimated burden being underestimated in the IFR. We, therefore, urge CMS to modify it as we suggest later in these comments.

Our response and the specific comments and issues are presented for each section of the *Proposed Rule* for File Code CMS-6026-IFC, as suggested in the *Federal Register*.

PROVISIONS OF THE *INTERIM FINAL RULE*

There is a fundamental problem with the *Interim Final Rule*. Important elements of CMS' approach to payment error measurement are not in the regulation itself, but in the preamble to the regulation. This is in contrast to the *Proposed Rule* where the payment error rate methodology was essentially in the text of the proposed regulation. We believe that the absence of the methodology from the body of the regulation raises significant issues:

- On page 58261 of the *Federal Register*, CMS states:

  "We anticipate producing a Medicaid FFS error rate for the FY 2007 Performance and Accountability Report (PAR) based on reviews conducted in FY 2006. In 2007, we expect to measure improper payments in FFS, managed care and eligibility components of Medicaid and SCHIP to be reported in the FY 2008 PAR."

  Even though Section IV, on page 58272 of the Federal Register, states that "Through these statutory provisions, this interim final rule...requires only those States selected for review to provide the contractor with the following information needed...", we suggest that the body of the regulation should be explicit that States should not have to report any information if a program will not be reported in the PAR.

- On page 58262 of the *Federal Register*, CMS states:

  "Under the national contracting strategy, a number of States will be selected for review. In FY 2006, the Federal contractor will group all States into three equal strata of small, medium and large based on States' annual FFS Medicaid expenditures from the previous year, and select a random sample of an estimated 18 States to be reviewed. The error rates produced by this methodology will provide the State with a State-specific error rate estimated to be within 3 percent precision at the 95 percent confidence level. For subsequent years, our sampling methodology will ensure that each State will be selected once, and only once, every 3 years for each program."

  Once again, this is not reflected in the regulation. It appears that States could be asked to submit all required information delineated in the regulation whether or not the information will actually be used for reporting in the PAR, even though Section IV, on page 58272 of the Federal Register, states that "Through these statutory provisions, this interim final rule...requires only those States selected for review to provide the contractor with the following information needed..." The body of the regulation should be explicit that a State should not have to report any information if the State's program has not been selected in the sample to be reviewed.

- Also on page 58262 of the *Federal Register*, CMS states:

  "We have not made a final determination about how eligibility errors will be measured. It is likely, however, that States would be active participants in the process. For example, though several options remain under consideration, it is possible that the States sampled for the medical and data processing reviews would be required to test for eligibility errors in a manner similar to that presented in the proposed rule."

  First, there should be no question that States will be "active participants in the process" since the response burden will fall upon the States. Second, to even suggest that the measurement of eligibility might follow what was in the *Proposed Rule* is to ignore the message from the States about response burden. CMS' own estimate in the *Proposed Rule* was that 83 percent of the response burden on the States would be for eligibility verification – 10 of the estimated 12 hours of response burden for each claim sampled.

- The entire methodology to be used is extra-regulatory, as it does not appear in regulation nor is there any reference to it in regulation. This is in contrast to the *Proposed Rule*. This means that CMS could change the methodology at will, including without reservation increasing the sampling precision, thus increasing the response burden on the States (for the eligibility component). CMS should not be permitted to unilaterally change any element of the methodology without affording the public an opportunity to comment on it through applicable administrative review requirements.

- There is nothing in the *Interim Final Rule* that would protect an unsampled State from having a payment error rate applied to it, based upon results from sampled States, and from CMS seeking "recoveries". There needs to be such protections for the States.

- There is no appeal procedure provided for in the *Interim Final Review* for a State to challenge the national contractor's State-specific error rates and attempts by CMS to recover alleged overpayments. States must be allowed to review the details of review findings and appeal a request or demand for alleged overpayments. We suggest that, preceding any formal Appeal Process that is triggered, and before the findings by the federal contractor are categorized as errors that result in state obligations for overpayment, the federal contractor should be required to hold an Exit Conference with the state, so that the state and the federal contractor have a common understanding of the federal contractor's findings. An Exit Conference would help mitigate circumstances that would place the State in an adversarial position with CMS since the state may have to advocate for the provider if the federal contractor interprets state policy in a manner that differs from the interpretation of state policy by the provider and where the state is in agreement with the provider's understanding of state policy. These elements need to be in the regulation.

- CMS should not be permitted to offset any alleged overpayments until a State's appeal has been resolved. This should be stated in the regulation.

- While CMS acknowledges unresolved methodological issues with SCHIP (e.g., a 10 percent cap on administrative expenses), a more fundamental issue for Rhode Island is that our State continues to exceed its annual SCHIP allotment. Although the State has been able to obtain "redistributed" funds, there is no guarantee that it will be able to do so in the future. Therefore, every dollar that would be spent on providing information to support determination of a SCHIP payment error rate (or, in the instance of eligibility, actually making such determinations) would have to be taken away from providing insurance coverage to the target population. Using CMS' own estimate of $620,000 per State (which we believe is understated), the State would need to cut 344 individuals from the SCHIP roles (at an average cost of $1,800 per individual per year) in order to comply with the *Interim Final Rule*. We do not believe that Congress intended that IPIA would force States such as ours to stop providing insurance coverage in order to undertake an administrative function that has yet to demonstrate any cost-effectiveness.

Our comments on individual sections of the regulatory changes in the *Interim Final Rule* follow.

Section 431.950 Purpose

The Improper Payments Information Act of 2002 requires Federal agencies to estimate erroneous payments nationally. We must once again point out that IPIA does not require State-specific error rate estimates. Yet, the payment error methodology being adopted by CMS includes State-specific error rates. This constitutes an unnecessary burden on the States.

Section 431.954 Basis and Scope

CMS acknowledged on page 58264 of the *Federal Register* that a number of commenters indicated that the *Proposed Rule* would make it "more difficult for providers because of increasing paperwork burdens, higher rates of denied claims, delays in payment, and sanctions." Among CMS responses to these commenters is: "We have analyzed the cost and burden on providers as part of this rule and determined that there will not be a significant cost or impact." However, no such analysis appears anywhere in the *Interim Final Rule* other than on page 58275 of *Federal Register* where CMS indicates "an impact analysis is not required under the RFA".

We would request, therefore, that whether or not the Regulatory Flexibility Act (RFA) requires it or not, that States such as ours that have never participated in PAM or PERM have an opportunity to review the analysis to which CMS referred so that we can make our own determinations of potential response burdens on providers. We remain very

concerned about the impact on providers and potential cost increases to the program because of it. In our State, the majority of Medicaid recipients are enrolled in managed care and 42 CFR 438.6(c) requires that managed care organizations be paid actuarially sound rates. Administrative requirements are one component of such rates. In addition, we are very concerned about the potential for erosion in provider participation in both FFS and managed care due to increases in response burdens.

Section 431.958 Definitions and Use of Terms

A number of definitions that were in the *Proposed Rule* were dropped in the *Interim Final Rule*, presumably because the States would no longer be making the error determinations themselves. Nonetheless, CMS reaffirms in the preamble that these definitions will continue to be used. Therefore, we believe it important to reiterate some of the concerns we raised concerning the *Proposed Rule* even though these definitions no longer exist in the regulation *per se*. For *adjustment to claims*, the *Proposed Rule* read that adjustments to claims made within 60 days of the payment adjudication should be included in the sample. We interpret this to exclude adjusted claims made after 60 days of the payment adjudication date from the sample. We disagree with this exclusion. This proposed 60-day limit would overstate the amount of the payment error, since adjustments do in fact occur after 60 days of the payment adjudication date. We believe that all adjustments to the claims should be included in the review at the time when the sample is drawn. We also do not believe that the 60-day limit has been adequately tested.

The *Proposed Rule*'s definition of *universe* relating to the sample includes paid and denied claims/line items submitted by providers, insurers, or managed care organizations (MCOs) that were received and processed for Medicaid and SCHIP payment during the sampling period. The inclusion of denied claims in the sample is questionable at best and in conflict with the definition of *payment* in the *Interim Final Rule*. We still disagree with CMS' decision to include such claims, as inappropriate.

Section 431.970 Information Submission Requirements

Use of the language "that include but are not limited to" in conjunction with the language in 42 CFR 431.970(g) means that CMS could require States to report State-specific payment error rates for Medicaid and SCHIP. This section should reflect CMS' intentions as expressed in the preamble to the *Interim Final Rule* that States will not be required to submit State-specific payment error rates to CMS.

Section 431.1002 Recoveries

We agree with the *Proposed Rule* that the Federal share of payment due to erroneous eligibility determination is exempt from this provision because those payments are addressed in section 1903(u) of the Act. We do not agree, however, with the provision that requires States to return the Federal share of overpayments actually identified in the sample claims reviewed for data processing and medical necessity in accordance with 42

CFR 433, subpart F, within 60 days. The Federal share of the overpayments should be offset by the amount of underpayments identified in the review.

In addition, any offset amount should be further reduced by an agreed-upon factor to represent the actual claims adjustments that were made but are not included in the payment error rate methodology that would inflate or exaggerate the amount of overpayments made.

Finally, the Federal share of overpayments should be returned within 60 days after the actual recovery of the overpayments.

Section 457.720 State Plan Requirements

CMS should provide a "preprint" for the States to fulfill these requirements in order to minimize the response burden on the States in this regard. This should be done only after CMS has resolved equitably outstanding SCHIP issues with respect to administrative cost caps and Federal SCHIP allotments being reached or exceeded by a State.

ADDITIONAL COMMENTS

On page 58261 of the *Federal Register*, CMS indicated that it was seeking comments on how best to measure error rates for managed care and SCHIP. For managed care, we believe that there only two considerations. First, was the individual eligible when payment was made to the managed care organization (MCO)? Second, was the payment to the MCO the proper amount (e.g., capitation code and amount)?

With respect to SCHIP, the same considerations apply for the managed care component. However, for those in the premium assistance program the only additional consideration would be whether any applicable cost-shares were correctly assessed the enrollee's family.

Thank you for consideration of our comments.

Sincerely,

John R. Young
Associate Director
Rhode Island Department of Human Services

- [Submitted: Original + 2 Copies]

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State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

November 1, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-6026-IFC
Medicaid Program and SCHIP Payment Error Rate Measurement
Interim Final Rule
Federal Register, Vol. 70, No. 192, October 5, 2005

Dear Sirs:

Thank you for allowing the South Carolina Department of Health and Human Services to comment on the interim final rule for Payment Error Rate Measurement (PERM) for Medicaid and the State Children's Health Insurance Program (SCHIP). This interim final rule sets forth requirements for States to provide the Centers for Medicare and Medicaid Services (CMS) with the information needed to comply with the Improper Payments Information Act, which requires CMS to estimate improper payments in Medicaid and SCHIP. South Carolina has participated in payment accuracy measurement (PAM) and payment error rate measurement (PERM) pilot projects during the past two years, and based on our experience I have serious concerns about the interim final rule. I acknowledge that in using a national contractor, CMS is trying to reduce some of the burden on States. However, I believe this approach is fraught with problems and will most likely produce an inaccurate and overstated error rate, which may unfairly penalize States and Medicaid providers. The interim final rule also does not provide enough information to allow States to accurately estimate the cost of compliance with PERM – and there will be state-level costs, regardless of whether a federal contractor is used. PERM will result in additional costs to States at the same time States are seeking to control the growth in their Medicaid programs.

Office of the Director
P. O. Box 8206 - Columbia, South Carolina 29202-8206
(803) 898-2504 - Fax (803) 898-4515

The interim final rule for PERM also comes at a time when South Carolina, through Healthy Connections, our Section 1115 demonstration waiver request, is trying to shift the focus away from traditional Medicaid fee-for-service payments to a beneficiary-directed menu of options that features multiple managed care and preferred provider plans. The proposed regulation may have little relevance to South Carolina's future Medicaid program.

Unfortunately, I have come to the conclusion that using a national contracting strategy to develop state-specific error rates is simply not viable, and will do little to improve the accuracy of States' Medicaid and SCHIP payments unless major changes are made. These concerns and our recommendations for revisions to the PERM regulation are discussed in detail in the following pages. South Carolina is committed to improving the accuracy of Medicaid payments and ensuring that our program is operated in the most efficient and effective manner possible. For this reason, I am urging that CMS allow more time to work with States to resolve these difficulties before any regulation is finalized. My staff and I are ready to collaborate with CMS and the other States in any way we can. Thank you for considering our comments. If you have any questions, please do not hesitate to contact Kathleen Snider at (803) 898-1050.

Sincerely,

Robert M. Kerr
Director

RMK/ssm

Enclosure

South Carolina Department of Health and Human Services Comments to
CMS-6026-IFC, Interim Final Rule
Medicaid and SCHIP Payment Error Rate Measurement
Federal Register, Vol. 70, No. 192, October 5, 2005

COMMENTS CONCERNING PROVISIONS OF THE INTERIM FINAL RULE

1. The Improper Payments Information Act (IPIA) requires CMS to estimate a national payment error rate. However, by basing the PERM regulation upon the development of state-specific error rates, CMS is shifting this responsibility to the States. At the same time, the interim final rule takes all control out of the States' hands regarding who will determine the state-specific error rates and how this will be done. Not only is this approach unfair, it will **not** result in an accurate error rate. It will be virtually impossible for a federal contractor, having to measure claims against 50 different sets of policies and payment rates, to be able to accurately determine whether a claim was paid correctly. But, the proposed interim final rule contains no provisions to allow States to validate potential errors identified by the PERM contractor. For example, South Carolina is participating in the PERM pilot project for this year, and we are currently determining our error rate for the final PERM report. Of 38 potential errors identified through the medical records and processing review, about 40% were determined to **not** be payment errors after further analysis by agency staff. We have worked with a very competent contractor for the PAM and PERM studies for almost three years. Even so, this contractor's knowledge of South Carolina's Medicaid program cannot measure up to in-house expertise. In addition, the interim final rule contains no provisions for States to appeal their error rate. Would the States' recourse for appeal follow the current deferral/disallowance process?

Recommendation: CMS should revise the interim final rule to guarantee that States will have the opportunity to review and validate potential errors identified by the federal contractor.

2. Since the national error rate is based on findings from 18 states, even if those States correct the errors, the national error rate for the next year will be based on a different set of 18 States and will not reflect the improvements made. By the time the first set of 18 States is sampled again, their corrective action plans for the initial errors found will be stale. The interim final rule contains little detail on required corrective action plans and how they will help CMS improve the national error rate over time. The corrective action plans could be useful to the individual States if CMS allows States to validate the errors to ensure they are truly payment errors, and also allows States some flexibility as to how they will develop and report corrective actions.

Recommendation: CMS should allow States flexibility in developing corrective action plans in order for these plans to be of maximum use to the States.

3. The interim final rule does not answer the question as to whether minor, technical errors in coding and documentation (i.e., a wrong date of service was used) would mean the payment was erroneous. Whose interpretation of State policy (the State's or the national contractor's) would establish the standard by which payments would be measured? However, according to the interim final rule, since States will not be performing the medical or processing reviews, *"...it is no longer necessary to define or clarify the review procedures."*

Recommendation: CMS should revise the interim final rule to allow States' continuing involvement in establishing review procedures and basing these procedures on the best practices already identified through the PAM and PERM pilot projects.

4. The interim final rule includes no specifics about requiring the federal contractor to make several attempts to obtain documentation from providers who fail to respond to requests for medical records. The experience of States participating in the PAM and PERM pilot projects is that a large percentage of errors were due to providers failing to send in the requested medical records. Since failure to submit medical documentation for a claim would be determined to be an improper payment, it is vital that the federal contractor be diligent in attempting to obtain medical documentation. What incentive will there be for the federal contractor to make repeated efforts to obtain medical records, especially since CMS is planning to pay a fixed rate per claim review? CMS needs to make a distinction between inadequate documentation of service versus situations where a provider fails to provide the required documentation to the PERM contractor. CMS also underestimates the cost and time involved in obtaining all the documentation required to review a Medicaid claim. This includes not only the medical record but also all other records and automated files that may contain information necessary to evaluate the claim. In our experience with the PAM and PERM pilot projects, this has been the most difficult and time-consuming part of the entire process.

Recommendation: CMS should require the federal contractor to demonstrate due diligence in obtaining the medical records needed for the claims reviews, and to inform the States when the contractor fails to collect the required documentation so the States would have an opportunity to step in. For the purposes of error rate determination, CMS should distinguish between inadequate documentation and provider non-response to documentation requests.

5. The interim final rule requires States to refund the federal share for Medicaid and SCHIP payments determined to be erroneous. This could create an administrative nightmare. If we did not want to sustain this loss of Medicaid

funding, we would have to recover the funds from providers. South Carolina, as all other States, must allow providers to appeal recoupment of funds. But, if States seek to recover improper payments from the providers, it will be very difficult to defend error findings determined by an external contractor, particularly when the State was not involved in the error determination. Would CMS be willing to refund the recoupment and revise the error rate if a hearing officer found for a provider? We believe this whole process will cost more than the actual funds recouped. Requiring a payback of improper payments changes the entire focus of PERM from an error rate study to a payment audit.

Recommendation: CMS should delete, or at least tailor, the requirement for repaying the federal share of erroneous payments. For example, the PERM regulation could specify that States would be required to repay only the amounts identified as an actual overpayment, once the State has had a chance to validate the contractor's findings. Claims with only "technical errors" that do not affect the payment should not be disallowed. In addition, CMS could adopt an error threshold similar to existing standards for the Single Audit, which require a dollar threshold of $10,000 for a reportable condition to be found. A dollar threshold for repayment would ensure that immaterial amounts would not be pursued for repayment.

6. Based on these concerns, therefore, one can only conclude that States must be continuously and closely involved in any determination of state-specific error rates. In the "Background" of the interim final rule, CMS acknowledges that: *"Since Medicaid and SCHIP are administered by State agencies according to each State's unique program characteristics, State participation in estimating improper payments was critical during the pilot projects and continues to be necessary and important for the Secretary to comply with the requirements of the IPIA."* But participation by the States will require significant state-level resources. Ultimately, the use of a national contractor will do little to ease the financial and administrative burdens that CMS has shifted to States in its effort to comply with the IPIA.

Recommendation: CMS should fully fund the State activities required for compliance with PERM.

7. The interim final rule contains multiple other requirements that would impact State costs, but still does not provide sufficient information to allow States to accurately estimate the burden PERM would place on them. First and foremost, CMS clearly states it will **not** eliminate the eligibility reviews from PERM nor combine them with the eligibility reviews already conducted under MEQC. The extent and nature of the PERM eligibility reviews are not established under the proposed regulation and have been left to a later issuance, but CMS acknowledges that *"...States will be required to conduct*

at least part of the eligibility tests..." States' initial concerns about the cost and burden of PERM were based on the August 2004 interim rule which called for an eligibility review on each of the approximately 2,000 claims that would be sampled. This review will be extremely expensive and duplicate current MEQC reviews. The use of a federal contractor will do nothing to alleviate States of this concern, if the interim final rule goes forward as proposed. Other factors impacting States' costs include:

- The number of State agency staff needed to provide technical assistance to the three different federal contractors. Staff will be required to help one contractor to collect all the required medical documentation and to understand the claims processing system in order to conduct the medical and processing reviews. They will have to provide information on policies and rates to another contractor and make sure they are receiving all up-dates. States will have to supply quarterly, stratified MMIS data to yet a third contractor.
- The cost to States for the increase in appeals from providers if they are required to refund Medicaid and SCHIP payments deemed erroneous.
- How much training and information technology resources States would have to commit in order to provide the federal contractors with Medicaid payment information.
- The time and resources involved to stratify claims data before sending it to the federal contractor, as this is strictly a PERM requirement that is not currently automated in the claims processing system.
- The type of review for managed care claims that ultimately would be required. This could have a significant impact on South Carolina as we move toward Medicaid reform with our 1115 waiver. The rule as proposed gives little detail about how managed care claims will be reviewed.
- The time and resources involved in developing and testing the required corrective action plans.

Recommendation: CMS should provide clarification on all aspects of the interim final rule so that States can plan for how they will comply. CMS should then fully fund the state activities required for compliance with PERM.

8. In addition to MEQC reviews, the interim final rule requires duplicate information already reported by the States. For example, the requirement that the States send the CMS contractor the previous year's claims and expenditure data will exactly duplicate what States have already sent for the Medicaid Statistical Information System (MSIS). It has already been suggested to CMS that the PERM sample be based on MSIS, but CMS dismissed this suggestion in the interim final rule with its comment that *"...MSIS data for Medicaid are too old to produce meaningful data on which*

the states could base effective corrective action plans." However, we send MSIS data to CMS each quarter, and therefore the data are not old when they are sent. CMS's response to this suggestion does not explain why MSIS data could not be used to pull the PERM samples. Also, the medical review activities for PERM duplicate to a large extent the in-patient hospital medical necessity reviews required under federal regulations starting at 42 CFR 476.70 (QIOs).

Recommendation: CMS should provide MSIS data to the federal contractors to use for drawing PERM samples, and should explore ways to avoid duplication with information already reported by the States.

9. The interim final rule proposes to develop a national error rate based on samples from 18 States, yet this approach is completely un-tested. In addition, the proposed rule contains many provisions, such as the requirement to include denied claims in the PERM sample, which will create difficult or possibly insurmountable problems for the federal contractor. One of the objectives during the PERM pilot project was to test a methodology for including denied claims, yet CMS apparently has established rules for inclusion of denied claims in PERM, without waiting for the results of the pilot studies. CMS' comments about denied claims in the interim final rule do not alleviate or resolve the problems inherent in this requirement. These problems include the lack of a common definition among States for denied claims and how they are treated by the claims processing system; statistical issues with including denied claims in the same error rate calculation as paid claims; how the dollar value of a denied claim would be determined; and whether the IPIA actually does require denied claims to be considered an improper payment. If CMS wants to determine if claims are properly denied, this should be a separate review. Otherwise, CMS is mixing vastly dissimilar items in the same sample and risking invalid results.

Recommendation: CMS should delete the requirement to include denied claims in the PERM sample, and should also review other components of the proposed interim final rule for validity. Also, the PERM methodology should be reviewed by an independent agency, such as the General Accounting Office, to ensure that it will yield valid results.

10. CMS dismisses States' concerns about the possibility of a claim being sampled for PERM that would be also included in an on-going Medicaid fraud and abuse case. This is a genuine concern of States. Normal protocols with Medicaid Fraud Control Units (MFCU) require that the State Medicaid agency not contact a provider or review any of his or her claims for the period under investigation. If the PERM contractor contacted a provider for the same medical records that might involve a claim included in a fraud investigation, this could "muddy the waters". This situation would be rare, and would

most likely involve only a single claim, so substituting that claim would not affect the error rate.

Recommendation: CMS should allow States to preview the claims chosen for the PERM sample, and if a claim was also part of an on-going fraud and abuse investigation, to substitute that claim.

11. It is not clear how CMS intends for PERM to help improve the efficiency and effectiveness of Medicaid and SCHIP. For example, CMS acknowledges that it has not conducted a cost-benefit analysis regarding PERM, but states that *"...savings will be realized over time through efficiencies gained by experience in estimating error rates, through disseminating findings from selected states, states' corrective action plans...".* This assumption is premature. As noted, the error findings established through PAM were primarily based on providers' failure to supply all the required medical records, not improper payments. This has nothing to do with cost savings or efficiency, which in our opinion is the objective of the IPIA, not just developing an error rate for its own sake.

Recommendation: CMS should evaluate the results of PERM studies for cost-effectiveness, and report these results to the Office of Management and Budget, in order to make recommendations for future revisions of the IPIA.

DELAWARE HEALTH
AND SOCIAL SERVICES

DIVISION OF
SOCIAL SERVICES

NOV - 7 2005

TELEPHONE: (302)

November 3, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS – 6026 – IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Delaware comments for Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement CMS-6026 - IFC

Dear Sir/Madam:

The purpose of this letter is to submit comments for Delaware Health and Social Services/Division of Medicaid & Medical Assistance (DMMA) on the proposed Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement Regulation (CMS – 6026-IFC) Federal Register/Vol. 70, No 192/Wednesday, October 5, 2005. Please respectfully accept our comments that are outlined below by section.

I. Background:

OMB has directed the Department of Health and Human Services (DHHS) to report estimate error rate for the Medicaid and SCHIP programs to OMB by November 15 of each year.

Delaware participated in YR 3 of the Payment Accuracy Measurement (PAM) Pilot Project and the Payment Error Rate Measurement (PERM) Pilot Project and both years requested a no-cost extension to complete the tasks that were required. We believe that the suggested timeline for reporting is unrealistic based on the proposed sample size of 800 – 1200 fee-for-service and managed care claims.

II. Provisions of the Proposed Rule:

Since Medicaid and SCHIP are administered by State agencies according to each State's unique program characteristics, State participation in estimating improper payments was critical during the pilot projects and continues to be necessary and important for the Secretary to comply with the requirements of the IPIA.

We are in agreement that each State has unique program characteristics. We don't understand how one contractor will be able to comprehend the complexities of all 18 state's unique program characteristics in less than a 10 month period. We believe that this will cause an inflated and inaccurate error rate for states that are selected. Additionally, states will have a significant amount of burden working with the contractor to educate them on the unique program characteristics. CMS should consider enhanced funding for staff members required to work on the PERM Project.

Based on medical, data processing, and eligibility reviews on a monthly random selection of a total of approximately 800 to 1,200 fee-for-service (FFS) and managed care claims (stratified between the components) each for Medicaid and SCHIP, States would produce and report to us State-specific payment error rates in Medicaid and SCHIP.

In the summary section of the Register it states "CMS will address estimating improper payments for Medicaid managed care and eligibility and SCHIP FFS, managed care and eligibility at a later time." This statement does not agree with the above statement. Additionally, the contractor was responsible for producing the error rates according to the Summary section "Based on the States' error rates, the contractor will calculate the improper payment estimates for these programs which will be reported by the Department of Health and Human Services as required by the IPIA." The statement above places the responsibility on the states.

States also would submit an annual report to us detailing the causes of errors and specifying actions to be taken to reduce the level of improper payments.

States will not be aware of the causes of the errors as they will be determined by the contractor and there is no claim/error re-review period built into the current process. Additionally, the regulation later states that "For subsequent years, our sampling methodology will ensure that each State will be selected once, and only once, every 3 years for each program."

The process for recoveries of improper payments under Medicaid is already set in statute. States must return the Federal share of overpayments identified through the medical and data processing reviews of the sampled claims within 60 days in accordance with existing statutory and regulatory requirements governing recoveries (section 1903 (d) (2) of the Social Security Act (Act) and 42 CFR part 433, subpart F).

If states are required to submit the federal share of overpayments back within 60 days is there an appeal process for states when providers show documentation when the funding is recouped from them. This process is extremely burdensome on states and providers. CMS should consider enhanced funding for PERM staff members required to complete this process.

We expect the determination of the eligibility error rate to require State participation and seek comments through the interim final rule on how such a rate could best be calculated within current Medicaid and SCHIP laws and regulations, and with minimal imposition on State resources.

In the previous pilot projects the eligibility review was time consuming and involved several high-level subject matter in-kind staff to prepare necessary documentation to verify eligibility. Delaware also contracted with Mercer to conduct the eligibility reviews. The projects involved 100 -200 cases to be reviewed for eligibility, however, the regulation as proposed referred to an eligibility review to be completed on all of the 800 – 1200 cases. We think this is an unrealistic number and extremely burdensome for states to complete and we welcome participation in the interim final rule.

We are also seeking comments on how best to determine an error rate for managed care in Medicaid and SCHIP.

If CMS is seeking comments on how to best determine an error rate for managed care in Medicaid and SCHIP why are states being selected for implementation by November of 2005?

III. Analysis and Response to Public Comments on the Proposed Rule:

We have not made a final determination about how eligibility errors will be measured. It is likely, however, that States would be active participants in this process.

In the previous pilot projects the eligibility review was time consuming and involved several high-level subject matter in-kind staff to prepare necessary documentation to verify eligibility. Delaware also contracted with Mercer to conduct the eligibility reviews. The projects involved 100 -200 cases to be reviewed for eligibility, however, the regulation as proposed referred to an eligibility review to be completed on all of the 800 – 1200 cases. We think this is an unrealistic number and extremely burdensome for states to complete. CMS should consider enhanced funding for PERM staff members to complete the project.

We believe this recommendation would not result in a standardized approach since the information that States would submit would be based on varying methodologies and that submitting cost savings information is not a measurement of improper payments, as required by IPIA.

Delaware strongly believes that the PERM Project is duplicative of both the Surveillance and Utilization Review System (SURS) and the Medical Eligibility Quality Control (MEQC) audits that are completed in every state.

Each State will have a State-specific error rate which will be the basis for a national error rate.

The IPIA only mandates that CMS produce a national error rate. Producing state specific error rates only adds additional burden on states and promotes the basis for comparison between states. Ultimately this could result in reduced funding to states for the Medicaid program which is not the intention of the IPIA.

For subsequent years, our sampling methodology will ensure that each State will be selected once, and only once, every 3 years for each program.

In order to plan for financial and operational staffing to implement the project states will need substantial notice prior to the year that they are selected and enhanced funding for the year of selection.

States did not believe the proposed rule's methodology would be cost-effective or realize savings. Some States and the advocacy groups were concerned that the proposed methodology would have an adverse effect on access to care as States increased or imposed new requirements on applicants for documented proof of eligibility to avoid errors.

We believe that providers will decide that the Medicaid program is just too much trouble and will in fact drop out of the Medicaid program.

A. Purpose and Basis:

Although Medicaid and SCHIP are jointly funded by the Federal and State governments, the programs are fully administered and operated by the States' Medicaid and SCHIP programs due to the flexibility States have in developing the coverage, benefit, and reimbursement aspects of the programs.

The purpose of having State's administer their own programs is due to them knowing the populations and needs of the program participants. We don't understand how one contractor will be able to comprehend the complexities of all 18 state's unique program characteristics in less than a 10 month period. We believe that this will cause an inflated and inaccurate error rate for states that are selected.

As a result, we must measure improper payments on a State-specific basis in order to produce a national payment error rate.

The IPIA only mandates that CMS produce a national error rate. Producing state specific error rates only adds additional burden on states and promotes the basis for comparison between states. Ultimately this could result in reduced funding to states for the Medicaid program which is not the intention of the IPIA.

States will not pay for the national contractor.

What is the funding source for the national contractor?

In addition, only those States selected for review each year will provide information necessary for claims sample selections and reviews will provide technical assistance as needed, and will implement and report on the corrective actions to reduce the error rate.

The quarterly submission of stratified data, policies, and rates is a significant change from the structure of the pilot projects. It is anticipated that this will only increase the level of work and coordination for states.

As a part of the rulemaking process, we have evaluated the burden and impact that these responsibilities will have on States and determined that there was significantly less impact on States and providers.

We strongly disagree with this statement. States will not only have to provide information to the contractor on a quarterly basis, they will have to educate the contractor on policies and answer questions as they arise. The states will still be responsible for the provider education and providing a provider file to the contractor. Additionally, states will have less control to follow-up on non-compliant providers resulting in an inflated error rate.

Though the burden and cost States would bear for eligibility testing in both Medicaid and SCHIP fee-for-service and managed care remains uncertain, the eligibility workgroup will make every effort to minimize both while establishing a useful and worthwhile methodology.

How was the eligibility workgroup selected and who is on the workgroup? Delaware is interested in being a part of this workgroup.

Finally, due to the minimal additional activity required by the regulation, we believe that States selected for review should not need to divert staff from other areas of program activities.

We strongly disagree with this statement. States will not only have to provide information to the contractor on a quarterly basis, they will have to educate the contractor on policies and answer questions as they arise. The states will still be responsible for the provider education and providing a provider file to the contractor. In addition, the eligibility review portion has not yet been addressed and was a large portion of the pilot projects.

Since Medicaid and SCHIP are partnerships between the Federal and State governments, we will rely on States' assistance throughout the error measurement process.

Delaware strongly agrees that measuring errors in programs is critical to program integrity, however, the proposed regulation lacks sound methodology and is not cost-effective for Federal and State governments. Our recommendation is to have an outside independent organization (GAO) review and comment on the methodology and processes.

Additionally, we will request that some States and/or their representatives be a part of the eligibility workgroup.

Again, Delaware is interested in participating in the workgroup.

We have reconsidered our approach and believe this strategy will provide more standardized measures across States.

Although the approach may bring some standardization we believe that due to the complexities of programs across states it will be difficult for one contractor to digest all of the differences and produce a useful and accurate error rate.

Under these regulations, the Administrator has the discretion to enforce the compliance regulations by withholding Federal matching funds in whole or in part until a State complies with Federal requirements.

This is unconscionable as an outside entity that is unaware about the individual state programs to review them for performance compliance and not offer any re-review time to states to verify findings. Finally there is indication that the Federal match will be withheld if States do not comply. This may be an action beneficial to States that will allow States to appeal the decision process before an administrative law judge.

We will analyze the cost/savings benefits when we have reliable findings, but we anticipate that savings will be realized over time through efficiencies gained by experience in estimating error rates, through disseminating findings from selected States, States' corrective action measures, and modeling best practices.

The pilot projects were completed over the last 4 years. Were there any cost/savings benefits or projections completed from the pilot studies? We recommend that a cost/savings benefit analysis be completed prior to national implementation of the project. If the final analysis shows no significant savings will steps be taken to eliminate PERM as a Federal mandate?

Since States and providers have different levels of systems sophistication, the contractor will work with States to determine the format for States to submit information.

We agree that submitting information using a claims-based sampling methodology administered electronically would improve the burden on states. It will also comply with the Paperwork Reduction Act of 1995.

We have analyzed the cost and burden on providers as part of this rule and determined that there will not be a significant cost or impact.

Is the cost and burden on providers and states available for states to review?

IPIA is merely a reporting requirement; it neither penalizes nor rewards States for acceptable or unacceptable error rates. However, States would still be required to reimburse CMS for the Federal portion of all improper payments identified through the medical and data processing reviews.

If states must pay back the Federal portion of error rates it is critical that states have an opportunity to re-review the potential error rates prior to finalizing them since they have a greater understanding of the complexities of each individual program.

The IPIA defines improper payment as "any payment that should not have been made or that was made in an incorrect amount including overpayments and underpayments."

There is no Federal match if there are no dollars paid to a provider due to a denial. How will states be expected to pay back the Federal match on a denied overpayment if nothing was paid?

The inclusion of denials is consistent with guidance from OMB, which has stated that improper payments include inappropriate denials of payment or service.

There is no Federal match if there are no dollars paid to a provider due to a denial. How will states be expected to pay back the Federal match on a denied overpayment if nothing was paid?

In the denominator, the non-scholastic (that is, deterministic) value of all line items paid over the sampling period is included, and denials enter the denominator as zero.

This statement infers that the Federal share will be collected from States for erroneous payments regardless of the payment amount and that it may not be cost-effective for States to recover the payment amount from providers due to administrative costs. If States do not meet the 60 day repayment timeline are there plans to withhold the match? Can we have clarification on the response?

The proposed rule was not intended to make exceptions or changes to another regulation. Therefore, we are not adopting this recommendation.

The response listed does not answer the original comment that was "States only return the Federal share of any payment after all the overpayments and underpayments are taken into consideration."

Provisions of the Interim Final Rule

States selected for review also will provide technical assistance as needed to allow the contractor to fully and effectively perform all functions necessary to produce the program error rates.

The national contractor will be paid to review the claims and States will be required to provide a significant amount of material to assist the contractor. States will work closely with the national contractor, however, we don't believe that it would be considered technical assistance to the contractor. CMS should provide guidance to its contractor.

In conclusion, Delaware believes that measuring error rates is critical to program integrity. Unfortunately after participating in 2 Years of the pilot projects we do not believe the proposed PERM methodology will be cost-effective and it will be extremely burdensome to States. CMS has made an assumption that the use of a Federal Contractor will decrease the State's workload. We believe the workload will increase based on the need to educate the Federal Contractor.

Harry B. Hill

Director, Medicaid & Medical Assistance

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VERMONT

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Agency of Human Services

November 3, 2005

NOV 14 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-6026-IFC
PO Box 8012
Baltimore, MD 21244-8012

The State of Vermont, Agency of Human Services, Office of Vermont Health Access (State Medicaid Agency) respectfully submits the following comments regarding Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS), 42 Code of Federal Regulations (CFR) Parts 431 and 457 [CMS-6026-IFC], Medicaid Program and State Children's Health Insurance Program (SCHIP), Payment Error Rate Measurement (PERM), Federal Register, October 5, 2005.

We would like to emphasize that:

- The Improper Payments Information Act of 2002 requires **federal** agencies to conduct the PERM review; a **federal** directive to **federal** agencies. Nowhere in the law is there any indication that the burden of this review is to be passed on to the states. States should not be required to support an unfunded mandate that is clearly the responsibility of a federal agency. If CMS proceeds with requiring states to participate in this process, all incurred costs (federal and state) should be borne 100% by the federal government.

- Denied claims should be removed from the universe of claims to be sampled. Federal funds are clearly not used to pay denied claims, and therefore we believe that denied claims should be removed from the sampling universe. If denied claims are not removed from the universe of claims to be sampled, then a complete and clear definition of "denied" claims should be presented for states to review and comment on.

- Projected administrative and cost burden estimates are still insufficient, particularly during the startup of a complicated program with many variables and state-to-state variation. States with prior Payment Accuracy Measurement (PAM) Pilot experience report that substantial staff time is required to perform initial and follow-up training for the federal contractor on state policies and to stay in continuous communication with them on a variety of day-to-day matters. Considerable criticism could be avoided by ensuring that states have the staff and financial resources to adequately support the federal contractor.

- A joint federal/state partnership should be implemented where the federal contractor is instructed to collaborate with states to ensure that they have a thorough, working knowledge of individual state programs and understands the complexities of each Medicaid program.

- Instead of selecting 18 states for the first year, we would recommend that a maximum of five states be selected for the first year due to the sheer magnitude of the reviews, extensive learning curve and rigid time constraint that the federal contractor is likely to encounter.

- We want the results to be a true reflection of how accurately Medicaid programs provide their services. States have a higher vested interest in the outcomes of the reviews then the federal contractor. We are concerned about the level of effort (i.e. requesting documentation only to prescribed limits) that the federal contractor will expend in accomplishing their tasks. We do not foresee the federal contractor being able to practice an acceptable level of diligence without a significant contribution from the state.

PERM imposes a significant burden on the State of Vermont:

- Selected states will be required to submit to the federal contractor annual Medicaid and/or SCHIP expenditures and quarterly stratified claims data. Stratification of quarterly claims data by individual states is an added burden on the State of Vermont, and could result in errors and inconsistencies between state PERM estimates. We recommend that the federal contractor conduct the quarterly claims stratification to ensure consistency across states and from quarter to quarter.

- We recommend that CMS enter into a dialogue with states to identify the components of a model corrective action plan before the PERM information collection process begins. We recommend that CMS establish a steering committee or other advisory group that includes state representatives to help ensure that the federal contractor consider all the logistical supports and address potential data collection issues before beginning onsite and interactive work (i.e., collecting medical review policies, manuals, and system documentation). For states with fiscal agents, obtaining systems documentation is likely to require assistance from fiscal agent staff which may involve contracting changes or unanticipated additional support expenses. If state representatives have the opportunity to participate through an advisory or other steering committee, states might be able to assist in reducing the extensive learning curve facing the federal contractor and also reduce demands on state staff to support the federal contractor.

- Much more information must be gathered for an adequate error determination than contemplated, including case histories going back a number of years. It would add substantially to state staff burdens if the federal contractor requested a download of Medicaid Management Information System (MMIS) files. These burdens are also likely to vary from state to state depending upon the capabilities of their MMIS systems. One approach to minimizing the data collection burden may be to utilize one-year-old data by extracting MSIS data that the federal government already collects.

  In addition, the federal contractor will likely need more information from the states than specified in the interim rule. To review and assess payment error accuracy, the federal contractor will need adjudicated claims data and medical policies, as well as a number of dynamic reference files/subsystems (e.g., third party liability, prior authorization, utilization history, processing edits, and pricing data to conduct claims audits). Providing these additional files and subsystem information to federal contractor will require staff time, effort, and management oversight unaccounted for in the interim rule's burden estimate.

- Providers historically are very guarded about the confidentiality of their files, and can be expected to provide a challenging environment to the federal contractor requesting records. Many state programs routinely request records multiple times and still must resort to creative tactics (e.g., having fiscal intermediaries assist in getting complete records). We recommend that CMS implement incentives in the federal contractor's scope of work to ensure they have thorough data collection protocols for identifying providers and obtaining complete documentation. We are concerned that if the federal contractor is less persistent in obtaining provider records than states, states' PERM rates could

unintentionally be inflated. We recommend that CMS collaborate with states to develop model letters, other processes, and guidance to ensure provider cooperation.

In closing, we appreciate the opportunity to comment and hope that the issues and recommendations we have outlined in this letter will be considered.

Sincerely,

Joshua Slen
Director

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NOV - 8 2005

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
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Centers for Medicare & Medicaid Services
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PO Box 8012
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Attention: CMS-6026-IFC

Re: Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement Interim Final Rule with Comment Period, 42 CFR Parts 431 and 457 File Code CMS-6026-IFC

Dear Sir/Madam:

New York State respectfully submits the enclosed comments regarding the Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement proposed interim final rule published in the October 5, 2005, *Federal Register* (70 *FR* 58259).

The rule, among other purposes, sets out the types of information that states would need to submit to allow the Centers for Medicare and Medicaid Services (CMS) to conduct medical and data processing reviews to estimate improper payments of claims made in the Medicaid fee-for-service (FFS) setting. CMS indicates that estimating improper payments for Medicaid managed care and eligibility and SCHIP managed care, FFS and eligibility will be addressed at a later time.

CMS proposes to engage a Federal contractor to complete the data processing and medical reviews to calculate the state-specific and national error rates. CMS notes that such a contractor was suggested in public comments received in response to the proposed rule published on August 27, 2004, "Medicaid Program and SCHIP Payment Error Rate Measurement" (69 *FR* 52620). The October 5, 2005 interim final rule also outlines future plans for measuring eligibility, which may include greater state involvement than the level required for the medical and data processing reviews.

We appreciate that CMS was receptive to the comments received in response to the draft Payment Error Rate Measurement (PERM) regulation and that CMS has proposed use of a Federal contractor, which will alleviate some New York State staffing and resource issues for this project. The interim final rule indicates that states will not pay for the Federal contractor.

New York State is committed to reducing errors in the Medicaid program and wants to assure that state and Federal resources are directed toward this goal in the most cost-effective and productive manner. Generally, we believe the October 5, 2005 CMS announcement does not contain enough information to allow a full evaluation of PERM and we would like to work collaboratively with CMS and other states to develop this concept. In that context, we offer the enclosed comments.

Thank you for considering our comments. Please do not hesitate to contact me if I can be of assistance.

Sincerely,

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management

Enclosure

New York State Comments
Interim Final Rule with Comment Period
File Code CMS-6026-IFC

Overall Comments:

New York State agrees with the decision by the Centers for Medicare and Medicaid services (CMS) to engage a Federal contractor for PERM reviews. The interim final rule declares that states will not pay for the Federal contractor. New York suggested use of a contractor in our 2004 comments. Although the states will not pay for the Federal contractor, states will still have sizeable expense and workload associated with PERM, as described in the interim final rule. For example, states must:

- provide information for claims sample selections and reviews;
- provide technical assistance; and
- implement and report on corrective actions.

Depending on upcoming CMS decisions of how PERM reviews will be conducted for Medicaid managed care and eligibility and State Children's Health Insurance Program (SCHIP) managed care, fee-for-service and eligibility, state expense and workload will increase.

We believe more collaboration between CMS and the states is appropriate to fully explore PERM critical issues and New York would be pleased to work with CMS and other states on this matter.

Additional comments follow, using the headings as directed in the Federal Register.

Provisions of the Proposed Rule

- The interim final rule briefly addresses the question of PERM eligibility ..., "We expect the determination of the eligibility error rate to require State Participation and seek comments through this interim final rule on how such a rate could best be calculated within current Medicaid and SCHIP laws and regulations, and with minimal imposition on State resources." If states must perform these tasks, then the burden on states increases dramatically. New York State is currently participating in the Federal PERM eligibility workgroup, which is discussing approaches to PERM Medicaid and SCHIP eligibility review. The interim final rule will at least partially duplicate state MEQC efforts. This duplication and the options for eligibility review should be fully considered by the PERM eligibility workgroup.

- New York State is a member of the Federal PERM eligibility workgroup and the subject of a Federal audit in preparation for PERM. In that context, it has become evident that a solid base of information and knowledge of Medicaid eligibility is of utmost importance in developing recommendations for PERM eligibility rules and auditing states' Medicaid programs. Given the complexity of Medicaid eligibility policy and the far-reaching effects it has on our most vulnerable populations, the necessity of having knowledgeable people involved in

this process is paramount. Furthermore, participants must be able to grasp and adjust to the differences among states' programs as no two states are exactly alike. Although the task of developing PERM eligibility recommendations must be completed within a reasonable period, an arbitrary, unrealistically short timeframe to complete this important task must not be imposed. Failure to provide sufficient time to complete this process could potentially result in jeopardizing states' abilities to successfully serve their Medicaid applicant/recipient populations.

Analysis and Response to Public Comments on the Proposed Rule

- "For subsequent years, our sampling methodology will ensure that each State will be selected once and only once, every 3 years for each program." New York State continues to believe that states will face staffing and budget issues as a result of PERM, although hopefully significantly fewer than if states needed to undertake the project completely on their own. To minimize the remaining burden, CMS should publish its review schedule well in advance so that states will know in what year their programs are subject to audit.

- States provide the Federal government with Medicaid Statistical Information System (MSIS) data, which may be duplicative with what is proposed.

Sampling Issues

- States selected for review will be required to submit quarterly stratified claims data to the contractor, who will pull a statistically valid random sample, each quarter, by strata. CMS believes "it is necessary for each selected State to submit stratified claims data because the contractor otherwise would not be able to complete the statistical aspect of the measurement process in a timely manner." New York State disagrees. CMS and the contractor can increase their staffing and resources to perform the stratification instead of delegating this burden to the states.

  CMS states it has reevaluated the original workload estimate associated with states submitting adjudicated and stratified claims data and has estimated the burden to be up to 200 FTE hours per quarter. Stratifying the claims before submitting them to CMS adds an extra layer of work for the states and could result in more FTE hours than 200. Stratifying adjudicated claims is not information "already on hand" for the state to submit and this process will take extensive resources and time to accomplish. This extra burden will necessitate states diverting staff and resources from other areas of program activity.

  Stratification of the claims by the individual states, versus by the Federal contractor, could also lead to inconsistency and error. The Federal contractor is in the best position to perform the required stratification in a consistent manner,

not the states. If the selected states stratify their claim data inconsistently, either state-to-state or within state quarter to quarter, the possibility exists for inaccurate state error rates and a subsequent unreliable and inaccurate national error rate. For these reasons, the Federal contractor should perform the stratification, not the states.

Review Procedures - Medical Reviews

- New York's experience in the PAM Projects found that obtaining the medical records was one of the most difficult and time consuming tasks in these reviews. New York conducted numerous follow-up activities to obtain the medical records from providers and questions whether the Federal contractor will be as diligent as the states in obtaining records. PERM requirements for the Federal contractor should include specifics on how often and in what manner the contractor must pursue obtaining the medical records and other documentation. This activity has a major impact on the review of claims and the subsequent error rates.

Recoveries

- The purpose of this interim final rule is to set forth states' requirements to provide information, which enables "the Secretary to produce a national improper payment estimate for Medicaid and the State Children's Health Insurance Program (SCHIP)." The interim final rule, however, appears to go beyond this purpose in requiring recoveries of overpayments, or in the case of payments based on erroneous Medicaid eligibility determinations, which exceed three (3) percent of state's total medical assistance expenditures, potential loss of Federal financial participation.

- Given the statement that this interim final rule does not address eligibility error rates, inclusion of specific recovery language by reference to Section 1903(u) of the Social Security Act with respect to erroneous eligibility determinations appears to exceed the stated scope of this interim final rule.

- In addition, although the eligibility workgroup is repeatedly referenced throughout the summary as being responsible for making recommendations on the best approach to conduct PERM Medicaid and SCHIP eligibility reviews, there is concern that certain requirements related to improper payments as a result of data processing and medical reviews (i.e., assigning a dollar error amount for underpayments) could be precedent setting for eligibility reviews.

- Regarding the requirement that states must return the Federal share of overpayments identified through the PERM medical and data processing reviews of sampled claims within 60 days of identification, what is the point of "identification" for PERM? The date of the final Federal PERM report or some other event?

Appeals

- Medical necessity determinations are complex, controversial and often require both the insight of experienced specialists and an extensive array of documentation. Medical necessity is often the subject of dispute and appeal. If a claim is found to be in error and recoupment is sought from the provider, administrative processes must be followed, including reaction to provider responses and, possibly, an administrative hearing.

  CMS expects the states to handle provider appeals resulting from PERM. "Appeals procedures are not modified by this rule and therefore have not been addressed. To summarize, if the State retrospectively denied the claim, the provider could appeal the denial under the existing State appeal process. If the provider won the appeal, we [CMS] would back the error out of the error rate calculation or, for claims received towards the end of the year, subsequent to the error rate calculation." This puts the states in the position of defending the Federal/contractor PERM actions and determinations. In addition, the states will need access to all documentation associated with the claim and denial to justify the collection and for state internal processes.

Provisions of the Interim Final Rule

- No routine interaction is indicated in the subject documents between the Federal contractor and the states. We believe such interaction is needed on a routine basis prior to, during and after the review to assure accuracy and quality. This kind of interaction is necessary because the Medicaid program is complicated and varies from state to state, therefore making it challenging for a contractor to accurately review a state's program. In particular, and due to the fact that we understand that state-specific error rates will be derived to determine a national error rate, we believe that states must have the opportunity to review any error cases and offer input on these "errors" prior to the Federal contractor finalizing cases as errors and defining the error rate.

- For each state, there should be a state liaison contact for the Federal contractor. This will facilitate a consistent communication path.

- Identification of claims adjustments increases the burden on the states. States will need to track the sample claims for a pre-determined amount of time and inform the Federal contractor of any changes in adjudication. This will result in sporadic staffing for this function. In New York State, original claims must generally be filed within 90 days of the date of service, but adjustments are allowed up to six years after the date of service. Therefore, adjustments will not necessarily occur within ninety days of claims payment, as required by the PERM review methodology.

- CMS should provide model corrective action plans to the states for comment as well as the time frames and requirements for preparing, submitting, implementing, monitoring and evaluating such plans.

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November 3, 2005

Centers for Medicare and Medicaid Services
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7500 Security Boulevard
Baltimore, MD 21244-8012

RE: Proposed Interim Final Rule – Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement (PERM)

Dear Sir:

We appreciate the opportunity to comment on the proposed interim final rule as published in the October 5, 2005 Federal Register, Volume 70, No. 192, page 58260.

Missouri continues to be greatly concerned over the proposed PERM rules. These rules will have a definite negative impact on our State's program integrity efforts, and a tremendous staffing burden, even with the assistance of Federal contractors.

A complete listing of the Missouri Division of Medical Services' comments/concerns is enclosed for your review.

Thank you for considering our comments.

Sincerely,

Q. Michael Ditmore, M.D.
Director

QMD/sb

Enclosure

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
services provided on a nondiscriminatory basis

MISSOURI DIVISION OF MEDICAL SERVICES – PROGRAM INTEGRITY UNIT
COMMENTS/CONCERNS REGARDING DRAFT "PERM" REGULATIONS
October 5, 2005

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
58261	Provisions of the Proposed Rule	States must return the Federal share of overpayments identified within 60 days in accordance with statutory and regulatory requirements governing recoveries (section 1903(d)(2) of the Social Security Act and 42 CFR part 433, subpart F. Recoveries of the Federal share of improper payments based on eligibility errors are subject to the provisions of section 1903(u) of the Act and related regulations at 42 CFR part 431, subpart P. This rule is being promulgated as interim final with comment period due to engaging a federal contractor rather than requiring States to produce error rates.	States could potentially have large overpayments. There is no explanation of how the State will work with the contractor on identified errors. There is no forum for additional information to be submitted for the error identified by the contractor to be reviewed by the State prior to final findings being issued.
58261	Analysis and Response to Public Comments on the Proposed Rule	In FY2006 we will use a Federal contractor to estimate improper payments from medical and data processing reviews in the fee-for-service component of Medicaid. Will group States into three equal strata of small, medium, and large based on States' annual FFS Medicaid expenditures from the previous year, and select a random sample of an estimated 18 states to be reviewed. For subsequent years, our sampling methodology will ensure that each State will be selected once, and only once, every three years for each program.	A single State could be selected for the add-on programs in successive years. The first time a state is reviewed will likely be the most cumbersome for the contractor and the state. As much advance notice as possible would be appreciated in order to plan for staffing.
58262	Analysis and Response to Public Comments on Proposed Rule	The error rates produced by this selection will provide the State with a State-specific error rate.	Missouri disagrees that a State-specific error rate is required as the purpose of the IPIA is to determine a national error rate. The goal of a national error rate should be obtainable by combining the sampled States' data without necessitating a State-specific error rate. This will lead to unwarranted comparison of States when, as stated in, A. Purpose and Basis, there is wide variation in States' Medicaid and SCHIP programs. Tracking of errors by States should still be achievable for the corrective action feature.
58262	Analysis and Response to Public Comments on Proposed Rule	The States selected for review will submit the previous year's claim data and expenditure data, not otherwise provided by CMS.	Missouri is concerned that previous year's data already provided to CMS which is to be used for sample size per stratum may not agree with the same type of stratification as submitted in the quarterly data. Missouri is participating in the Payment Error Rate Measurement (PERM) project and chose to program each stratum based on the Medicaid Statistical Information System (MSIS) definitions but did not elect to use the existing state MSIS files. In particular, these files did not exclude adjustments nor include denied claims or premium payments.

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
58263	Purpose and Basis	Regarding the cost and burden that the proposed rule would have imposed on States, our adoption of the commenter's recommendation to engage a Federal contractor to estimate a component of improper payments significantly reduces the cost and burden and addresses this concern. States will not pay for the national contractor. In addition, only those States selected for review each year will provide information necessary for claims sample selections and reviews will provide technical assistance as needed, and will implement and report on the corrective actions to reduce the error rate. The States will be reimbursed for these activities at the applicable administrative Federal match under Medicaid and SCHIP. Finally, due to the minimal additional activity required by the regulation, we believe that States selected for review should not need to divert staff from other areas of program activities. Regarding compliance, the regulations that govern State compliance with Federal requirement in Medicaid and SCHIP are 42 CFR 430.35 and 457.204, respectively. Under these regulations, the Administrator has the discretion to enforce the compliance regulations by withholding Federal matching funds in whole or in part until a State complies with Federal requirements.	The additional activity required will be more time-consuming than expected; and staff **will** be diverted from other areas of program activities. We are already stretched to meet expected goals. How does CMS believe that the liaison communications will occur? Do most States plan to use staff from Program Integrity or Program Operations as the designated contact persons? Since the States are still required to share all of their claims processing procedures, policies and provider enrollment, and payment methodologies with the private contractor(s), it would be to the State's best interest to know what steps are taken by the contractor(s) working on the PERM project. While the interim rule addresses that the sampled States will be reimbursed for providing information and technical assistance, it is also stated on page 58274 that the estimated annualized hours per State per program is 1630 hours. This is approximately 40 weeks per program or almost 2 full-time State personnel. Missouri believes this will create a diversion as the PERM sample of 300 claims has been much more involved than anticipated. It will be difficult to obtain approval for additional staff based on the rotating selection schedule with experienced staff needed to provide the required level of technical assistance. The additional requirement on page 58266 is up to 200 FTE hours per quarter for submitting stratified data that will be primarily the State's fiscal agent responsibility. Will the statistical contractor(s) determine the required format? Who is responsible for the costs of formatting the data into the required format and delivering the data to the contractor(s)? The reimbursement for providing information and technical assistance should be a 100% federal funding, which is not specifically stated in the regulation.

MISSOURI DIVISION OF MEDICAL SERVICES – PROGRAM INTEGR ITY UNIT
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October 5, 2005

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
58264 58266	Claims Universe and Sampling (Sampling Issues)	In FY2007, we will estimate separate error rates for FFS and managed care. We will also produce a combined FFS and managed care error rate for each State for each program in addition to providing a national error rate for each program.	Missouri agrees with the comments that the capitated and Fee-For-Service (FFS) error rates are not comparable. The majority of the managed care sample has less processing requirements and errors. This can be present a difference in the error rate "image" between FFS and programs. We believe CMS, or its designee, for the final reports should include an explanation addressing this difference.
58267	Overpayment and Underpayment Errors	In order to be in compliance with IPIA, we must follow OMB guidelines regarding total gross overpayments and underpayments to derive error rate estimates. However, we also intend to report separately the amount of overpayment and underpayments.	Missouri commends CMS's intention to also report the amount of overpayment and underpayment separately.
58268	Review Procedures – Medical Reviews	Entire comments and responses in Section D1. CMS responses to nearly all medical review concerns are States are no longer performing the medical reviews, and will not incur the cost of the reviews.	During the PERM pilot, Missouri's medical record reviewers pursued additional documentation in about 70% of records requested. Though our initial request gave an itemized list of records requested to indicate doctor's orders, daily progress notes, etc. were needed. We frequently received only summaries. Obtaining complete documentation required more than 5-to-6 provider contacts and several different persons being notified of items missing. Inadequate documentation may be a frequently cited error by the contractor(s) because the contractor has no incentive to relentlessly request missing information. Obtaining complete medical records is a time-consuming process. We do not believe the regulation takes this into account. We have little confidence the contractor will be as successful as the State in getting that last piece of information that proves medical necessity. The state will have to repay the federal portion if the contractor is not as responsible as the state would be. States that use the InterQual Level of Care Criteria for inpatient stay approvals may be at risk for a higher error rates. Approval by InterQual Criteria requires review of specific chart notations such as daily progress and nursing notes, daily lab or x-ray reports, etc. States that use InterQual regarding inpatient stays as opposed to States that use a specific length of stay by diagnosis have a higher likelihood of inadequate documentation.

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
58268	Review Procedures-Medical Reviews (continued)		Information that identifies diagnosis is much easier to obtain than daily notes and specific lab or procedure documentation that must meet specific criteria for approval. Is the CMS contractor licensed and trained for InterQual Reviews? The criterion is proprietary information. States that require copyright materials for program standards, such as InterQual, cannot provide a copy of this document for the federal contractor(s). The regulation does not address guidelines for efforts to be made by the Federal contractor to obtain medical records, as was included in the PERM Resource Guide. Missouri believes that the PERM Resource Guide should be used with an additional thirty (30) days due to the Federal contractor's involvement. Also, to have a reliable error rate determination, other than no response or inadequate documentation, States must be considered a partner in the efforts to obtain the medical records. While Missouri has a good rapport with providers and obtaining documentation, in the PERM project approximately 70% of the claims required additional documentation. Missouri used the PERM resource template for the initial request. The Federal contractor needs to be vigilant in its efforts in obtaining records.

MISSOURI DIVISION OF MEDICAL SERVICES – PROGRAM INTEGRITY UNIT
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58269	Review Procedures – Data Reviews	Entire comments and responses in Section D2.	Our State manuals may not address every billing situation. Bulletins are used to clarify situations that have not yet been added to the manuals. At times, our program operation's staff is contacted to make judgments regarding non-typical situations. Verification of non-typical situations is not easily found by simply consulting manuals and bulletins, or by review of system edits. This can make processing reviews a complicated and time-consuming effort. The contractor has no incentive to aggressively pursue obtaining complete documentation or to delve into policy and procedures more deeply to discern State procedures and policies. We strongly believe the contractor must be required to consult with the State regarding all claims they determine to have errors. The State needs to have ample opportunities to identify if there is a special circumstance, or if documentation is inadequate. Missouri's experience in the PERM pilot is that the processing review was much more complicated and time-consuming than originally planned. This portion will require an enormous amount of the State's technical assistance in explanations and clarifications.
58269	Eligibility	Entire comments and responses in Section D3.	Missouri concurs with the comment eligibility reviews are the most staff and cost intensive of the three review components. Missouri recommends the eligibility workgroup be either opened to all States that are interested in participating or establish a review process of draft documents as in the PERM project. There needs to be a procedure for input prior to the promulgation process. A possible solution to address the barriers in eligibility verification and the date of service (DOS), which can be 12 months from payment, is a maximum DOS of no greater than 3-6 months from the payment date in the claim sampling methodology.

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
58270	Eligibility	Entire comments and responses in Section D3.	Missouri agrees that a claim for a person who is eligible for Medicaid or vice versa should not be totally ineligible; and, the difference in service payment should be the over or underpayment. If this is not accepted, at least this variation should be noted with some quantitative information in the final report. For expenditure of funds, the person could be eligible for the exact services or a portion of the service. We acknowledge that it is not the intent of CMS to have outcomes affecting beneficiary eligibility or program coverage. However, it is a possibility that as error rates are published, this will impact these matters, and not always based on a complete understanding of what is being measured.
58271	Recoveries	The requirement to return the Federal share of erroneous payments within 60 days of identification is longstanding in statute and regulation and does not allow for only cost-effective recoveries.	Final notice of overpayments greater than $500 must afford providers an appeal process with an Administrative Hearing Commission for our State. This is a legal process, and the witnesses are the individuals who conducted the review. Will the CMS contractor be available to participate in provider appeals and hearings processes? If not, Missouri will be faced with returning the federal share without provider notice or performing a complete re-review. This will require getting copies of the medical record and the Federal contractor(s) documentation to make an independent decision. Missouri has found strict adherence to the wrong date of service policy results in recoupment of funds for which the provider cannot rebill due to timely filing. We have allowed a discrepancy in dates in past audits if the service or procedure is only a day off and are not duplicated in the claims history for that timeframe. We have addressed this discrepancy as a provider education issue.
58272	Appeals	A few commenters stated that the proposed rule is devoid of any discussion of provider notification and appeal rights when an error has been determined, nor does it provide an a opportunity to appeal or indicate how the process would use the existing notification and appeals process for both beneficiaries and providers.	This section did not address state appeals to CMS regarding disagreements in errors identified by the CMS contractors. We believe there must be a process whereby this can occur prior to inclusion in the error rate calculation. A State appeal should be a mandatory procedure due to variation in the States' programs, implementation by a Federal contractor(s), and possible staff

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
			turnover of the contractor(s) for the ongoing PERM. This is an important part of the process necessary to ensure the rates published are as accurate as possible, and that the states understand the "error" so that appropriate corrective action can be implemented. The response of altering the State's error rate if a provider's appeal reverses the decision is not feasible for Missouri as the appeal process can take at least two years. The PERM process should be to identify problems and not a provider error rate/collection procedure. It should be the state's decision on how to pursue any overpayments or underpayments identified from PERM.
58272	Provisions of Interim Final Rule	This section requires States selected for review to provide the contractor with the following information: • The previous year's claim data and expenditures; • Quarterly adjudicated and stratified claims data from the review year; • All medical policies in effect and quarterly medical policy revisions needed to review claims; • Systems manuals; • Current provider contact information; verified and/or updated as necessary to have providers submit medical records needed for medical reviews; • Repricing of claims the contractor determines to be in error; • Claims that were included in the sample, but the adjudication decision changed due to the provider appealing the determination and the state overturning the original decision; • An annual report on corrective actions to reduce the error rate; and	It would require an individual with extensive knowledge of State policies and procedures to be aware of what might constitute special handling of a particular claim, and where to find the documentation or authority to approve the service or item for payment. How will contractors know if additional requests for information is needed from other agencies or state contracted entities as well those by the billing provider? What is the CMS contractor's incentive to pursue these types of issues? Will states be initially or continually involved in guiding the contractor regarding these specifics? Will this be prior to final reports or as the claim is in review? The amount of time to be dedicated to this effort is unknown but we suspect it could be a potentially heavy load of issues to explain to a contractor who will likely have no experience in our state. There is no reference to recipient/beneficiary eligibility and files, which for the 4th year PERM project is necessary for the processing review.

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
		• Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining error rates in Medicaid and SCHIP. States selected for review also will provide technical assistance as needed to allow the contractor to fully and effectively perform all functions necessary to produce the program error rates."	
58273	Collection of Information Requirements	Comments are solicited on the following issues: • The need for the information collection and its usefulness in carrying out the proper functions of our agency; • The accuracy of our estimate of the information collection burden; • The quality, utility, and clarity of the information to be collected; and • Recommendations to minimize the information collection burden on the affected public, including automated collection techniques. The burden associated with this requirement is the time and effort necessary for States to collect this information and provide it to the Federal contractor. The annualized number of hours that may be required to respond to the requests for information equals 58,680 hours (1630 hours per State per program).	This estimate may not be accurate as there are so many unknowns about the potential contractor and the particular claims that are pulled. The amount of time actually invested by state staff to assist contracted staff, could be quite different.
58274	Regulatory Impact Statement	CMS' response to State comments are continually repeated in print, "State burden and cost are significantly reduced under this revised strategy."	Cost estimates for the review in it's entirety seem exorbitant and will use resources that may be better spent on the provision of services for recipients rather than spending additional dollars for reviews that will recoup possibly significant funds from the State ultimately leading to smaller budgets for the administration of services to recipients. The States may incur many more costs in terms of man-hours than in copying costs. Will the $1 million - $2 million dollars invested per State for the reviews justify the amount of errors identified for Federal repayment?

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
58275	Anticipated Effects	The interim final rule with comment period is intended to measure errors in Medicaid and SCHIP. States would implement corrective actions to reduce the error rate, thereby producing savings. However, these savings cannot be estimated until after the corrective actions have been monitored and determined to be effective, which can take several years.	This is an unknown that will not be evident for several years. It is quite a large, labor intensive, complex activity that will have high costs in paying contractors, in use of State staff information sharing and liaison activities, and which may ultimately have a very large negative impact to the State should the review show a high error rate. Again, we comment that the State needs to be able to investigate and defend potential errors found by the contractor prior to the publishing and repayment processes.

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November 3, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
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7500 Security Boulevard
Baltimore, MD 21244-8012

RE: Proposed Interim Final Rule – Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement (PERM)

Dear Sir:

We appreciate the opportunity to comment on the proposed interim final rule as published in the October 5, 2005 Federal Register, Volume 70, No. 192, page 58260.

Missouri continues to be greatly concerned over the proposed PERM rules. These rules will have a definite negative impact on our State's program integrity efforts, and a tremendous staffing burden, even with the assistance of Federal contractors.

A complete listing of the Missouri Division of Medical Services' comments/concerns is enclosed for your review.

Thank you for considering our comments.

Sincerely,

Q. Michael Ditmore, M.D.
Director

QMD/sb

Enclosure

MISSOURI DIVISION OF MEDICAL SERVICES – PROGRAM INTEGRITY UNIT
COMMENTS/CONCERNS REGARDING DRAFT "PERM" REGULATIONS
October 5, 2005

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
58261	Provisions of the Proposed Rule	States must return the Federal share of overpayments identified within 60 days in accordance with statutory and regulatory requirements governing recoveries (section 1903(d)(2) of the Social Security Act and 42 CFR part 433, subpart F. Recoveries of the Federal share of improper payments based on eligibility errors are subject to the provisions of section 1903(u) of the Act and related regulations at 42 CFR part 431, subpart P. This rule is being promulgated as interim final with comment period due to engaging a federal contractor rather than requiring States to produce error rates.	States could potentially have large overpayments. There is no explanation of how the State will work with the contractor on identified errors. There is no forum for additional information to be submitted for the error identified by the contractor to be reviewed by the State prior to final findings being issued.
58261	Analysis and Response to Public Comments on the Proposed Rule	In FY2006 we will use a Federal contractor to estimate improper payments from medical and data processing reviews in the fee-for-service component of Medicaid. Will group States into three equal strata of small, medium, and large based on States' annual FFS Medicaid expenditures from the previous year, and select a random sample of an estimated 18 states to be reviewed. For subsequent years, our sampling methodology will ensure that each State will be selected once, and only once, every three years for each program.	A single State could be selected for the add-on programs in successive years. The first time a state is reviewed will likely be the most cumbersome for the contractor and the state. As much advance notice as possible would be appreciated in order to plan for staffing.
58262	Analysis and Response to Public Comments on Proposed Rule	The error rates produced by this selection will provide the State with a State-specific error rate.	Missouri disagrees that a State-specific error rate is required as the purpose of the IPIA is to determine a national error rate. The goal of a national error rate should be obtainable by combining the sampled States' data without necessitating a State-specific error rate. This will lead to unwarranted comparison of States when, as stated in, A. Purpose and Basis, there is wide variation in States' Medicaid and SCHIP programs. Tracking of errors by States should still be achievable for the corrective action feature.
58262	Analysis and Response to Public Comments on Proposed Rule	The States selected for review will submit the previous year's claim data and expenditure data, not otherwise provided by CMS.	Missouri is concerned that previous year's data already provided to CMS which is to be used for sample size per stratum may not agree with the same type of stratification as submitted in the quarterly data. Missouri is participating in the Payment Error Rate Measurement (PERM) project and chose to program each stratum based on the Medicaid Statistical Information System (MSIS) definitions but did not elect to use the existing state MSIS files. In particular, these files did not exclude adjustments nor include denied claims or premium payments.

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58263	Purpose and Basis	Regarding the cost and burden that the proposed rule would have imposed on States, our adoption of the commenter's recommendation to engage a Federal contractor to estimate a component of improper payments significantly reduces the cost and burden and addresses this concern. States will not pay for the national contractor. In addition, only those States selected for review each year will provide information necessary for claims sample selections and reviews will provide technical assistance as needed, and will implement and report on the corrective actions to reduce the error rate. The States will be reimbursed for these activities at the applicable administrative Federal match under Medicaid and SCHIP. Finally, due to the minimal additional activity required by the regulation, we believe that States selected for review should not need to divert staff from other areas of program activities. Regarding compliance, the regulations that govern State compliance with Federal requirement in Medicaid and SCHIP are 42 CFR 430.35 and 457.204, respectively. Under these regulations, the Administrator has the discretion to enforce the compliance regulations by withholding Federal matching funds in whole or in part until a State complies with Federal requirements.	The additional activity required will be more time-consuming than expected; and staff **will** be diverted from other areas of program activities. We are already stretched to meet expected goals. How does CMS believe that the liaison communications will occur? Do most States plan to use staff from Program Integrity or Program Operations as the designated contact persons? Since the States are still required to share all of their claims processing procedures, policies and provider enrollment, and payment methodologies with the private contractor(s), it would be to the State's best interest to know what steps are taken by the contractor(s) working on the PERM project. While the interim rule addresses that the sampled States will be reimbursed for providing information and technical assistance, it is also stated on page 58274 that the estimated annualized hours per State per program is 1630 hours. This is approximately 40 weeks per program or almost 2 full-time State personnel. Missouri believes this will create a diversion as the PERM sample of 300 claims has been much more involved than anticipated. It will be difficult to obtain approval for additional staff based on the rotating selection schedule with experienced staff needed to provide the required level of technical assistance. The additional requirement on page 58266 is up to 200 FTE hours per quarter for submitting stratified data that will be primarily the State's fiscal agent responsibility. Will the statistical contractor(s) determine the required format? Who is responsible for the costs of formatting the data into the required format and delivering the data to the contractor(s)? The reimbursement for providing information and technical assistance should be a 100% federal funding, which is not specifically stated in the regulation.

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58264 58266	Claims Universe and Sampling (Sampling Issues)	In FY2007, we will estimate separate error rates for FFS and managed care. We will also produce a combined FFS and managed care error rate for each State for each program in addition to providing a national error rate for each program.	Missouri agrees with the comments that the capitated and Fee-For-Service (FFS) error rates are not comparable. The majority of the managed care sample has less processing requirements and errors. This can be present a difference in the error rate "image" between FFS and programs. We believe CMS, or its designee, for the final reports should include an explanation addressing this difference.
58267	Overpayment and Underpayment Errors	In order to be in compliance with IPIA, we must follow OMB guidelines regarding total gross overpayments and underpayments to derive error rate estimates. However, we also intend to report separately the amount of overpayment and underpayments.	Missouri commends CMS's intention to also report the amount of overpayment and underpayment separately.
58268	Review Procedures – Medical Reviews	Entire comments and responses in Section D1. CMS responses to nearly all medical review concerns are States are no longer performing the medical reviews, and will not incur the cost of the reviews.	During the PERM pilot, Missouri's medical record reviewers pursued additional documentation in about 70% of records requested. Though our initial request gave an itemized list of records requested to indicate doctor's orders, daily progress notes, etc. were needed. We frequently received only summaries. Obtaining complete documentation required more than 5-to-6 provider contacts and several different persons being notified of items missing. Inadequate documentation may be a frequently cited error by the contractor(s) because the contractor has no incentive to relentlessly request missing information. Obtaining complete medical records is a time-consuming process. We do not believe the regulation takes this into account. We have little confidence the contractor will be as successful as the State in getting that last piece of information that proves medical necessity. The state will have to repay the federal portion if the contractor is not as responsible as the state would be. States that use the InterQual Level of Care Criteria for inpatient stay approvals may be at risk for a higher error rates. Approval by InterQual Criteria requires review of specific chart notations such as daily progress and nursing notes, daily lab or x-ray reports, etc. States that use InterQual regarding inpatient stays as opposed to States that use a specific length of stay by diagnosis have a higher likelihood of inadequate documentation.

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58268	Review Procedures-Medical Reviews (continued)		Information that identifies diagnosis is much easier to obtain than daily notes and specific lab or procedure documentation that must meet specific criteria for approval. Is the CMS contractor licensed and trained for InterQual Reviews? The criterion is proprietary information. States that require copyright materials for program standards, such as InterQual, cannot provide a copy of this document for the federal contractor(s). The regulation does not address guidelines for efforts to be made by the Federal contractor to obtain medical records, as was included in the PERM Resource Guide. Missouri believes that the PERM Resource Guide should be used with an additional thirty (30) days due to the Federal contractor's involvement. Also, to have a reliable error rate determination, other than no response or inadequate documentation, States must be considered a partner in the efforts to obtain the medical records. While Missouri has a good rapport with providers and obtaining documentation, in the PERM project approximately 70% of the claims required additional documentation. Missouri used the PERM resource template for the initial request. The Federal contractor needs to be vigilant in its efforts in obtaining records.

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58269	Review Procedures – Data Reviews	Entire comments and responses in Section D2.	Our State manuals may not address every billing situation. Bulletins are used to clarify situations that have not yet been added to the manuals. At times, our program operation's staff is contacted to make judgments regarding non-typical situations. Verification of non-typical situations is not easily found by simply consulting manuals and bulletins, or by review of system edits. This can make processing reviews a complicated and time-consuming effort. The contractor has no incentive to aggressively pursue obtaining complete documentation or to delve into policy and procedures more deeply to discern State procedures and policies. We strongly believe the contractor must be required to consult with the State regarding all claims they determine to have errors. The State needs to have ample opportunities to identify if there is a special circumstance, or if documentation is inadequate. Missouri's experience in the PERM pilot is that the processing review was much more complicated and time-consuming than originally planned. This portion will require an enormous amount of the State's technical assistance in explanations and clarifications.
58269	Eligibility	Entire comments and responses in Section D3.	Missouri concurs with the comment eligibility reviews are the most staff and cost intensive of the three review components. Missouri recommends the eligibility workgroup be either opened to all States that are interested in participating or establish a review process of draft documents as in the PERM project. There needs to be a procedure for input prior to the promulgation process. A possible solution to address the barriers in eligibility verification and the date of service (DOS), which can be 12 months from payment, is a maximum DOS of no greater than 3-6 months from the payment date in the claim sampling methodology.

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58270	Eligibility	Entire comments and responses in Section D3.	Missouri agrees that a claim for a person who is eligible for Medicaid or vice versa should not be totally ineligible; and, the difference in service payment should be the over or underpayment. If this is not accepted, at least this variation should be noted with some quantitative information in the final report. For expenditure of funds, the person could be eligible for the exact services or a portion of the service. We acknowledge that it is not the intent of CMS to have outcomes affecting beneficiary eligibility or program coverage. However, it is a possibility that as error rates are published, this will impact these matters, and not always based on a complete understanding of what is being measured.
58271	Recoveries	The requirement to return the Federal share of erroneous payments within 60 days of identification is longstanding in statute and regulation and does not allow for only cost-effective recoveries.	Final notice of overpayments greater than $500 must afford providers an appeal process with an Administrative Hearing Commission for our State. This is a legal process, and the witnesses are the individuals who conducted the review. Will the CMS contractor be available to participate in provider appeals and hearings processes? If not, Missouri will be faced with returning the federal share without provider notice or performing a complete re-review. This will require getting copies of the medical record and the Federal contractor(s) documentation to make an independent decision. Missouri has found strict adherence to the wrong date of service policy results in recoupment of funds for which the provider cannot rebill due to timely filing. We have allowed a discrepancy in dates in past audits if the service or procedure is only a day off and are not duplicated in the claims history for that timeframe. We have addressed this discrepancy as a provider education issue.
58272	Appeals	A few commenters stated that the proposed rule is devoid of any discussion of provider notification and appeal rights when an error has been determined, nor does it provide an a opportunity to appeal or indicate how the process would use the existing notification and appeals process for both beneficiaries and providers.	This section did not address state appeals to CMS regarding disagreements in errors identified by the CMS contractors. We believe there must be a process whereby this can occur prior to inclusion in the error rate calculation. A State appeal should be a mandatory procedure due to variation in the States' programs, implementation by a Federal contractor(s), and possible staff

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			turnover of the contractor(s) for the ongoing PERM. This is an important part of the process necessary to ensure the rates published are as accurate as possible, and that the states understand the "error" so that appropriate corrective action can be implemented. The response of altering the State's error rate if a provider's appeal reverses the decision is not feasible for Missouri as the appeal process can take at least two years. The PERM process should be to identify problems and not a provider error rate/collection procedure. It should be the state's decision on how to pursue any overpayments or underpayments identified from PERM.
58272	Provisions of Interim Final Rule	This section requires States selected for review to provide the contractor with the following information: • The previous year's claim data and expenditures; • Quarterly adjudicated and stratified claims data from the review year; • All medical policies in effect and quarterly medical policy revisions needed to review claims; • Systems manuals; • Current provider contact information; verified and/or updated as necessary to have providers submit medical records needed for medical reviews; • Repricing of claims the contractor determines to be in error; • Claims that were included in the sample, but the adjudication decision changed due to the provider appealing the determination and the state overturning the original decision; • An annual report on corrective actions to reduce the error rate; and	It would require an individual with extensive knowledge of State policies and procedures to be aware of what might constitute special handling of a particular claim, and where to find the documentation or authority to approve the service or item for payment. How will contractors know if additional requests for information is needed from other agencies or state contracted entities as well those by the billing provider? What is the CMS contractor's incentive to pursue these types of issues? Will states be initially or continually involved in guiding the contractor regarding these specifics? Will this be prior to final reports or as the claim is in review? The amount of time to be dedicated to this effort is unknown but we suspect it could be a potentially heavy load of issues to explain to a contractor who will likely have no experience in our state. There is no reference to recipient/beneficiary eligibility and files, which for the 4th year PERM project is necessary for the processing review.

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		• Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining error rates in Medicaid and SCHIP. States selected for review also will provide technical assistance as needed to allow the contractor to fully and effectively perform all functions necessary to produce the program error rates."	
58273	Collection of Information Requirements	Comments are solicited on the following issues: • The need for the information collection and its usefulness in carrying out the proper functions of our agency; • The accuracy of our estimate of the information collection burden; • The quality, utility, and clarity of the information to be collected; and • Recommendations to minimize the information collection burden on the affected public, including automated collection techniques. The burden associated with this requirement is the time and effort necessary for States to collect this information and provide it to the Federal contractor. The annualized number of hours that may be required to respond to the requests for information equals 58,680 hours (1630 hours per State per program).	This estimate may not be accurate as there are so many unknowns about the potential contractor and the particular claims that are pulled. The amount of time actually invested by state staff to assist contracted staff, could be quite different.
58274	Regulatory Impact Statement	CMS' response to State comments are continually repeated in print, "State burden and cost are significantly reduced under this revised strategy."	Cost estimates for the review in it's entirety seem exorbitant and will use resources that may be better spent on the provision of services for recipients rather than spending additional dollars for reviews that will recoup possibly significant funds from the State ultimately leading to smaller budgets for the administration of services to recipients. The States may incur many more costs in terms of man-hours than in copying costs. Will the $1 million - $2 million dollars invested per State for the reviews justify the amount of errors identified for Federal repayment?

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58275	Anticipated Effects	The interim final rule with comment period is intended to measure errors in Medicaid and SCHIP. States would implement corrective actions to reduce the error rate, thereby producing savings. However, these savings cannot be estimated until after the corrective actions have been monitored and determined to be effective, which can take several years.	This is an unknown that will not be evident for several years. It is quite a large, labor intensive, complex activity that will have high costs in paying contractors, in use of State staff information sharing and liaison activities, and which may ultimately have a very large negative impact to the State should the review show a high error rate. Again, we comment that the State needs to be able to investigate and defend potential errors found by the contractor prior to the publishing and repayment processes.