Submitter : Ms. Linda Barnett **Date:** 09/20/2006

Organization : Delaware Dept of Health and Social Svcs

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-6026-IFC2-1-Attach-1.DOC

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Management Services

"DMS – Serving Those Who Serve Delaware"

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement – CMS-6026-IFC2

Dear Sirs:

The Delaware Office of Quality Control within the Department of Health and Social Services wishes to be on record with our major concerns regarding the above-referenced Interim Final Rule.

Duplication of Effort: This proposal causes the states to do 'eligibility reviews' twice – once for the standard MEQC process and once for PERM. We recognize that the latter requirement is only once in every three years (which is a problem to be addressed below), but the duplication is still a fact. We understand there are different laws governing the two processes, but it is baffling to think that such a barrier cannot be overcome by working with Congress. Why would they want the states to duplicate their efforts in this way? State and federal budgets are stretched as it is. Delaware recommends that states be allowed the option of substituting PERM for MEQC but without the MEQC disallowance.

'Once in three years' cycle: The regulation specifies that states are to review eligibility for SCHIP and Medicaid cases once every three years. If staff are hired to do this, what happens to those staff in the two "off years"? If consultants are hired to handle it, this will be a burden on states in any event, as the consultant staff will need to be managed and monitored, in addition to which they will need to be initially trained on the state's programs. In addition, consultants are typically very costly to hire.

Sample: The regulation is very confusing about the sample size that is needed. Is each state supposed to review approximately 500 active cases for SCHIP and 500 for Medicaid, or will a small state (such as ourselves) be able to draw a smaller sample? The stratification component of the sample is extremely complex, and initial discussions with the Information Technology staff here indicate that this is going to be a difficult challenge for them. Why couldn't the sample be selected the same way it is for MEQC? So much else is duplicated – and yet this is not. It doesn't make sense.

Dissemination of Information: All states should have an opportunity to review, digest and comment on the nature of the eligibility reviews. The regulations do not contain any of the specifics on the details of the eligibility reviews. There will surely be questions and discussion in this area that should not be restricted to the states due to commence eligibility reviews in FY 2007. CMS should make the policy for eligibility reviews available to all states.

Sincerely,

Linda D. Barnett

Linda D. Barnett, PhD
Manager, Quality Control

Submitter :

Date: 09/22/2006

Organization : **TX Hlth & Human Svcs Comm Ofc of Inspector General**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC2-2-Attach-1.PDF

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

September 22, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC2
P.O. Box 8013
Baltimore, MD 21244-8013

Attention: CMS-6026-IFC2

Re: Interim Final Rule Comments—Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement (PERM)

The Health and Human Services Commission, Office of Inspector General (HHSC-OIG), is submitting this comment letter on Medicaid and SCHIP Payment Error Rate Measurement. HHSC-OIG is commenting on the interim final rule proposed published in the August 28, 2006, *Federal Register* (71 *FR* 166) for the Centers for Medicare and Medicaid Services (CMS). Texas submitted comments on August 12, 2005, September 26, 2005, and again on November 4, 2005, in response to information collection notices describing CMS' proposals to retain a federal contractor to conduct the medical and systems review components of PERM. The following are our updated comments.

- Overall, there is a gross under-estimation of the cost to the States. The Final Cost Estimate for FFS, SCHIP FFS, and Managed Care Reviews are for information collection only (see pages 51079 – 51080). The following costs were not included in the assumptions and taken into consideration:
    - Provider Education – See page 51060
    - Difference Resolution Process – See page 51066
    - Technical Assistance – See page 51071
    - Corrective Action Plans – See page 51071

- The States' concerns about cost estimates and the reliance on the PAM/PERM pilots as to make the estimates were ignored. The PAM/PERM pilots did not include provider education, difference resolution process, and corrective action plans. Although the response stated that the States' would only be responsible for information collection and technical assistance, the final cost estimate does not include the cost for providing technical assistance. See pages 51068 and 51069.

- The States' concerns about the costs and resources for corrective action plans were ignored. The response communicates that CMS intends such plans to be carried out within the restriction of the ongoing program (see page 51071), which seems to be in conflict with the goal for States to reduce payment error rates.

- The volume of information and training that will be necessary to transfer to the federal contractors creates a substantial burden on states both financially and in relation to staffing resources.

- The financial and staffing burden is exacerbated by the requirement that there be three (3) federal contractors to deal with each state. This will require 3 times the state effort to train and coordinate with federal contractor staff. Different phases or information transfer may be occurring simultaneously, thus creating greater confusion and coordination failures regarding the status of each project and varied points of contact within each federal contractor.

- Establishing a state error rate is not required by the Improper Payments Information Act of 2002 (IPIA). To establish such a payment error rate wastes additional funding that could be utilized more economically. State audits could be conducted that identify inappropriate claims payment and resolved through the same methodology as routine federal audits. That would be substantially more economical and less wasteful in both funding and resources. It would accomplish the same purpose.

- The cumulative effect of the passage of recent federal statutes has created a federal assault on states that is resulting in a deterioration of the relationship between the federal government and the states. It has also created duplication of effort. Federal routine operational audits are continuing to be conducted on states while adding audits of Eligibility, Medicaid, and SCHIP through the new federal PERM regulations; audits and oversight of Medicaid and Medicaid program integrity through new federal Medicaid Integrity Program (MIP) regulations; continued oversight by the CMS program and General Accounting Office (GAO); and continuing Medicaid Eligibility Quality Control (MEQC) audits of the Eligibility program. Federal partners and legislators need to take stock of the backlash from states that are brewing. An evaluation of the cumulative effect on states of all of the various federal auditing and oversight activities needs to receive strong consideration for revision and reasonableness. CMS has stated that they are "considering" methods to minimize duplication of efforts regarding the eligibility reviews. No guarantee was given that this would occur. CMS did not address the duplication of effort related to the Medicaid program leading states to speculate this will not be addressed.

- CMS responds that states have had input into the development of the PERM regulations. CMS stated that the states have been active participants in the PERM regulatory process. We disagree with that representation. Only 2 states were involved in meetings with CMS during

regulation development. There have been 3 all-state calls on PERM regulations not all of which had a PERM representative to answer questions or provide information. These calls did not result in any substantive comments by the states due to the number of unanswered questions by CMS. It is hard for states to make reasonable comments and suggestions when they cannot get sufficient information from CMS from which suggestions could be developed. As a result, CMS has not provided an acceptable forum for state participation in the development of PERM regulations. When there was a PERM representative, the majority of time was used by that representative providing the same information that the states already knew, but not providing substantive responses to questions and points of clarification from the states.

- CMS has made the decision to include claims from providers that are under active fraud investigation in the universe of claims from which a sample will be pulled. This decision was made after many states expressed concerns with the inclusion of these claims. To include these claims is absolutely unfair to the states. States' program integrity investigations should not be placed in jeopardy by insensitive federal regulations. Federal and state partners should be working together to combat fraud and abuse. This decision presents several problems, three of which are discussed below:
  (1) These claims will likely result in a decrease in response from fraudulent and abusive providers thus skewing the error rate to an inappropriately inflated rate.
  (2) Many times there is no way to identify false, fraudulent, or abusive claims in an automated claims payment system or through manual prior authorization. Regardless of how many edits/audits a system may have, the type of fraud would make it impossible for a state to identify. The only way to determine that type of error is to interview recipients and/or review medical records. It is impossible for states to do this on any type of regular basis. It has to be done on an exception basis when potential fraud or abuse is detected subsequent to payment. This also skews the error rate to an inappropriately inflated rate.
  (3) Providers are alerted that someone is looking at their claims thus allowing them to take corrective action to create, alter, or destroy documentation and evidence that could have been used to successfully prosecute the provider and recover the overpayment. Contacting these providers and requesting records places in jeopardy complex and expensive investigations.

- On netting over and underpayments, the rule states, *"We must comply with OMB guidance (M–03–13) on IPIA, which defines improper payments as including overpayments and underpayments and requires that these payments be measured separately."*

  While over and underpayments may be separate control errors, a bottom-line error rate estimate must net out over and under-payments, as already required at http://oig.hhs.gov/fraud/cia/docs/ciafaq1.html, as follows:

"For each unit reviewed, the reviewer should determine the dollar difference between the provider's actual reimbursement and the amount the provider should have been reimbursed (based on contractor and the Centers for Medicare and Medicaid Services ("CMS") policies). Once all sampling units have been reviewed, the results of each sampling unit are added together (underpayments may be netted or offset from overpayments). The resulting calculation is the net overpayment. The reviewer divides the net overpayment by the total dollar amount of the sample. The resulting calculation is the net financial error rate.

A. Net overpayment received as a result of the errors (subtract the underpayments from the gross overpayment);

B. Net financial error rate of the sample (amount of net overpayment divided by the total dollars in the sample)"

- The means of reporting PERM error rates contradicts existing Federal guidance.

  "We expect that the average sample size will be 1,000 FFS claims and 500 managed care claims per State program in order to achieve a 3 percent precision level at the 95 percent confidence level (based on a range estimated during the PAM/PERM pilots)."

- To prevent oversampling and, thereby, to reduce costs to all participants, sampling should stop once the desired precision and confidence level are reached. The sample size of 1,000 is likely excessive for many States, particularly given that error rates in PAM and PERM do not support a sample size of 1,000.

  For example, using the highest error rate of 13.5% from the 2002 Texas PAM report, a 3% precision and 95% confidence are realized in a sample of 500. Using historical error rates to set sample sizes was discussed with and allowed by CMS during PAM and PERM pilots, a practice which should continue here. At minimum, pilot States should be permitted use of their historical error rates to calculate sample sizes.

- The rule should state whether attribute and/or variable sampling will be done, on which it is silent. The choice can greatly affect sample size and hitting target precisions.

- GAGAS (3.49 et seq.) requires a Quality Control Review of contractor-generated PERM working papers and findings. This review should be conducted by an independent, uninformed, and reasonable third party. No findings should be deemed final or actionable in any way until this review is complete. Moreover, the cost of this review must be included in the rules, which presently appears not the case.

- Also, GAGAS (5.27 et seq. 6.43 et seq., and 8.32 et seq.) requires that States must review and comment on draft findings. This should occur prior to the Quality Control Review of the final report.

- The rule is unclear on whether error rates will be reported based on claims, dollars, or both. Nor does it state if extrapolations will be done and, if so, at which confidence level. Both points should be specifically addressed. If extrapolations will not be done, they should be specifically excluded in the rules.

- Since State-level strata are dollar-weighted, State error rates should also be weighted against dollar volume in other States when computing the national error rate. This will ensure that each State's contribution to the error rate is obvious, appropriately balanced, and consistently calculated at all levels of data analysis. This is particularly relevant since *"We will use the State rates as the basis for the national rates"* but that *"comparisons among States should not be made since each program and its policies vary."*

- States should herein be allowed to calculate error rates based on either the difference method or the ratio method, as was done in both PAM and PERM pilots.

- The response to concern that the mere possibility of a national estimate is problematic given data aggregation issues and program variances was:

  "By drawing a stratified random sample of States and then reviewing a random sample of claims within each of those States (using each State's program policies), we are able to obtain an estimate of the national error rate...."

  This circular logic is not an adequate response and requires a leap of faith to accept. There is no "how" in this response. More information is needed to ascertain the credibility of this assertion.

- *"The States will be reimbursed for these activities at the applicable administrative Federal match under Medicaid and SCHIP."*

  This creates a partially unfunded mandate to the States since reimbursement is at the applicable match level rather than full cost reimbursement. Moreover, the reimbursement of the difference is merely hypothetical and based on an unestablished belief that *"Since we are estimating improper payments in a select number of States, primarily through a Federal contracting strategy, we believe the State cost to measure error rates has been substantially reduced. We anticipate that savings will be realized over time through disseminating findings from selected States, States' corrective action measures, and modeling best practices."*

Note further that this assumes that review burdens mandated by State legislatures will remain otherwise static over time.

- *"States had already grouped their claims similarly in their Medicaid Management Information System (MMIS); therefore, we believe that the stratification of claims for submission should not be burdensome to States."*

  This pre-supposes that States have fully, correctly, and timely conformed their MMIS's to these strata, a dubious assumption at best, as both PAM and PERM revealed.

- *"We did not adopt the recommendation to select a nationwide sample because we believed that it was not the best overall method to meet the requirements of the IPIA and OMB guidance. There is no national sampling framework for SCHIP claims."*

  No rationale for the rejection of this potentially fruitful recommendation is given. Also, the absence of a national sample framework for SCHIP does not mean that there could or should not be one.

- If *"States will be measured against their individual rates rather than a national average"* what is the operational benefit of a national error rate to the States?

  The eligibility component in PERM is redundant and possibly inadequate. It is redundant vis-à-vis MEQC which already reviews a larger and more useful sample. Also, the proposed PERM eligibility sample size may be too small to be valid and reliable at the State level and, therefore, will be of little utility when aggregated at the Federal level. It makes better sense to incorporate PERM into MEQC and use the same MEQC claims for the PERM work, particularly since *"SCHIP and Medicaid will be measured in the selected States at the same time."*

- *"However, for CMS to review the claim, the difference in findings must be in the amount of $100 or greater."*

  While seeking efficiency is wise, a claim that is not reviewed by CMS as part of the Difference Resolution Process should not contribute to the error rate since, by design, no final determination will be made on whether it is, in fact, an error.

- *"The IPIA directed the Office of Management and Budget (OMB) to provide guidance on implementation. OMB defines significant erroneous payments as annual erroneous payments in the program exceeding both 2.5 percent of program payments and $10 million (OMB M–03–13, May 21, 2003)."*

Does this mean that erroneous payments in PERM which fail to meet either of these thresholds at the State level will not be reported and/or not be repayable to the Federal government? The rules should so specify.

Regarding §431.998

- The process does not include a time frame for the federal contractor's review of the state's request for difference resolution. A time frame for the contractor's review should be specified.

- The process does not include a time frame for CMS final resolution when the state and the contractor do not agree. A time frame for CMS's review of a state's appeal should be specified.

- §431.998(b)(1) requires the difference in findings be $100 or greater in order for a state to enter the difference resolution process.
    - Is this $100 per claim? If so, and if there are multiple claims on which a state wants to appeal, then it would not be cost effective to submit a written request per claim, but rather batch the claims in one request. However, if a batch request is used, the state may be in danger of exceeding process time frames. How would the contractor timely review and respond to individual requests for review? No data exists to estimate whether the amount of requests for reconsideration would be onerous to the state, the contractor, or CMS.
    - If a request to review a difference in findings may not be for a claim less than $100, then a "finding" of less than $100 per claim should not be considered an "error" since no due process is allowed.

- §431.998(c) does not exclude an error that, following appeal, is determined not to be an error (a non-error is still an error). Is this what the IPIA intended? Since this is a new endeavor for CMS, no data exists to estimate the number of such "errors." CMS should determine how many such errors are successfully/unsuccessfully appealed through the resolution process prior to implementing the interim rule in order to properly determine whether a state's error rate is significantly skewed as a result.

Regarding §431.1002

- Delete this section. If this section serves merely as a cross-reference to existing recovery requirements, then it serves no purpose as a requirement, rule, or regulation specific to PERM and should not be included.

Please let me know if you have any questions or need additional information. Sharon Thompson, Senior Policy Advisor, is serving as the lead staff on this matter and can be reached at 512-491-2055 or by email at Sharon.Thompson@hhsc.state.tx.us.

Sincerely,

Brian Flood
Inspector General

Submitter : Mr. George Hoover **Date:** 09/25/2006

Organization : PA CHIP and adultBasic Office

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-6026-IFC2-3-Attach-1.DOC

Pennsylvania's Children's Health Insurance Program

Office of
CHIP & adultBasic
Insurance Program

adultBasic
Health Insurance for Adult Pennsylvanians

September 22, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC2
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-6026-IFC2 Interim Final Rule with Comment Period

To Whom It May Concern:

Pennsylvania appreciates the opportunity to comment on the CMS-6026-IFC2 Interim Final Rule of August 28, 2006. Pennsylvania is a separate State Children's Health Insurance Program (SCHIP) state and, therefore, the Insurance Department is responding on behalf of its SCHIP program. Pennsylvania's SCHIP program meets the requirements specified under Section 2103 of the Act.

Pennsylvania currently has contracts with eight (8) insurance companies (contractors) to provide health care coverage under the SCHIP. Pennsylvania's primary role is to regulate the policies and procedures that have been implemented to operate the SCHIP. Several functions, including administrative, are performed by its contractors.

In reviewing the latest publication of the Federal Register on August 28, 2006, Pennsylvania presents the following questions for clarification in order to determine the best method to comply with the PERM requirements.

On Page 51053, II. Provisions of the October 5, 2005 Interim Final Regulations, Section B. Use of Federal Contractors, Review Contractor, it states that the RC will conduct the data processing reviews, most likely on site, using the systems information provided by the State. **On Page 51071, Section E. State Requirements, 2. Technical Assistance,** it states again that the data processing reviews will most likely be performed on site, and **on Page 51074, IV. Provisions of This Interim Final Regulation, 1. Managed Care, c. Managed Care Review Process,** it states that it is anticipated that the managed care data processing reviews will be conducted on site, along with the Fee for Service claims data processing reviews. What if a SCHIP program does not process its own claims, but claims are processed through their contracted insurance companies? Will the on-site data processing review be performed at the insurance companies? If not, how will the data processing review be handled?

1300 Strawberry Square Harrisburg, Pennsylvania 17120 telephone 717-705-6830 fax 717-705-1643

On Page 51055, III. Analysis of and Responses to Public Comments, Section A. Purpose, Basis and Scope, 1. Payment Error Rates, it states that states are required to provide information necessary for the Secretary to monitor program performance under the SCHIP statute at section 2107 (b)(1) of the Act, a**nd on Page 51067, Section E. State Requirements, 1. Collection of Information, a. State's Role,** it states that the contractors do not need to establish data use agreements with the national contractors because the contractors will collect the required information for CMS under the authority of the SCHIP statute at section 2107(b)(1) of the Act. In regards to the authority that CMS and the national contractors have to gather the requested information, what if a state is not able to produce certain data like mental health and substance abuse due to state confidentiality guidelines? Will that be counted as an error? Does the universe of claims definitely include pharmacy, mental health, and substance abuse claims? Do state confidentiality guidelines override SCHIP regulations?

On Page 51064, III. Analysis of and Responses to Public Comments, Section C. Expanded FY 2007 Error Rate Measurements, 1. Eligibility, a. Cost and Burden, it states that CMS will provide in the regulation that the agency conducting the PERM eligibility reviews must be functionally and physically separate and independent from the state agency responsible for Medicaid and SCHIP policy and operations, including eligibility determinations. **On Page 51074, IV. Provisions of This Interim Final Regulation, 2. Eligibility,** it states that CMS has provided that the eligibility reviews must be conducted by a state agency independent of the state agency responsible for Medicaid and SCHIP policy and operations (that is, an agency that is functionally and physically separate) including making the program eligibility determinations. **On Page 51076, IV. Provisions of This Interim Final Regulation, 2. Eligibility, c. Eligibility Review Process,** it states CMS adopted the recommendation that the eligibility reviews be conducted by a state agency which is independent of the state agency making the program eligibility determinations. **On Page 51082, Part 431 – State Organization and General Administration, Definitions and Use of Terms,** it defines agency, for purposes of the PERM eligibility reviews and this regulation, as the agency that performs the Medicaid and SCHIP eligibility determinations under PERM and excludes the state agency as defined in the regulation. A state agency is then defined as the agency that is responsible for determining program eligibility for Medicaid and SCHIP, as applicable, based on applications and redeterminations. **Page 51083, Basic Elements of Medicaid and SCHIP Eligibility Reviews, (a) General Requirements, (2)** states the agency and personnel responsible for the development, direction, implementation, and evaluation of the eligibility reviews and associated activities, including calculation of the error rates under this section, must be functionally and physically separate from the state agency and personnel that are responsible for Medicaid and SCHIP policy and operations, including eligibility determinations. If a SCHIP stand-alone state office does not determine

eligibility because it is done at the contracted insurance companies, along with contracting with the providers, providing benefits and processing claims, but the SCHIP stand-alone office does develop the policies and procedures, does this definitely exclude the SCHIP office from doing the eligibility reviews? If so, several references specifically state that another state agency has to do the eligibility reviews while several references just say an agency. Is a state allowed to contract with an appropriate private vendor to conduct the eligibility review or is the review limited to another state agency?

We appreciate your consideration in this matter. If you need further clarification, please contact Lowware Holliman, Chief, Quality Assurance Division at 717-783-1437.

Sincerely,

George L. Hoover
Deputy Insurance Commissioner
CHIP and adultBasic Coverage

GLH/LH/RA/rd

bcc: Lowware Holliman
Correspondence File
CMS file
Robyn Arva

Submitter : rose feild

Date: 09/25/2006

Organization : CMS

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Claude Singleton

Organization : NJ Div of Medical Asst & Hlth Services

Category : State Government

Date: 09/26/2006

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-6026-IFC2-5-Attach-1.PDF

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712
Telephone 1-800-356-1561

JON S. CORZINE
Governor

CLARK BRUNO
Acting Commissioner

ANN CLEMENCY KOHLER
Director

September 25, 2006

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-IFC2

The following comments are respectfully submitted in response to the Notice of Interim Final Rule with Comment Period (CMS-6026-IFC2) published in the Federal Register on August 28, 2006.

We are compelled to preface our comments with the following perspectives: We are perplexed in regards to the Notice of Information Request, concerning CMS-10184 (OMB#: 0938-NEW), published in the Federal Register on September 1, 2006 and how it relates to CMS' partnering strategy with the States.

1. The States were lead to believe that each program would be measured on an alternating or rotational basis. However, by deciding to measure Medicaid and SCHIP performance in the same State in the same year, CMS has unilaterally decided to increase the State's burden and costs by 100%. Accordingly, the estimated cost to States is now over one million dollars instead of $532,000. This unilateral decision is contrary to Supporting Statement (Item 12, Burden Estimate) issued with the initial request to gain OMB approval (71 FR 30410) published on May 26, 2006.

2. It is questionable as to whether CMS' decision to slightly increase the eligibility sample sizes to produce an equal sample size per stratum each month is based on sound statistical theory. To increase the sample size for the given reason does not consider the limited resources and fiscal constraints under which most States operate.

3. Giving States the option to contract out the PERM eligibility reviews to entities outside of the State Medicaid agency is not a practical option at this late date and the cost would be a prohibiting factor. Contractor competency is mostly an unknown variable; and we presume that, like MEQC, contractor competency could not be used as a defense against a faulty error rate – even if warranted.

4. We do not perceive or suggest that the use of PERM eligibility reviews to satisfy requirements for the MEQC program would be permissible under 1903(u) of the Social Security Act. We recognize that the sampling and eligibility review methodology is inherently different between the two requirements; and MEQC excludes SCHIP cases. Consequently, we are convinced that the findings are not transferable. We recommended that CMS consider allowing States the option to use MEQC staff to perform PERM eligibility reviews. CMS could treat the PERM eligibility review like a Medicaid pilot project, carrying-over the State's most recently certified MEQC Error Rate through the PERM participation period. In other words, the State's most recently certified MEQC Error Rate could satisfy the MEQC reporting requirements while our MEQC staff performs PERM eligibility reviews.

CMS admits that, to a certain extent, PERM requirements duplicate MEQC requirements. To require PERM Medicaid eligibility reviews, PERM SCHIP eligibility reviews and MEQC eligibility reviews to be performed concurrently is impractical and not in this State's best interest.

CMS-6026-IFC2:

Section I: Background: No Comment

Section II: Provisions of the 10/5/2005 Interim Final Regulations: No Comment

Section III: Analysis of and Responses to Public Comments

1. (71 FR 51061): Regarding medical reviews, we are somewhat concerned that an error will be cited for cases in which there is insufficient documentation or documentation is received after the federal contractor's submission deadline, in addition to no documentation on file. Our concern pertains to, for example, the documentation of preventative or diagnostic services. Since the dispute-resolution process is limited to improper payments in excess of $100, we may be at the mercy of the federal contractor for certain claim types. Therefore, we recommend the elimination of a dollar threshold.

2. **(71 FR 51064): Our concerns over this partnership has further intensified with CMS' unilateral decision to "...provide in the regulation that the agency conducting the PERM eligibility reviews must be functionally and physically separate and independent from the State agency responsible for Medicaid and SCHIP policy and operations, including eligibility determinations." We disagree that having the PERM eligibility reviews remain in this Division would pose a potential conflict of interest: This is one of CMS' more troublesome decisions in which we vigorously oppose.**

   To exclude the State Medicaid Agency from the PERM eligibility review process is most unwise and amounts to heavy-handedness for the given reason. We recommend that, to be consistent with providing the option to contract out the PERM eligibility process, States be afforded the option, like MEQC, to keep PERM functionality in-house. Otherwise, management through a third party entity is certain to add another bureaucratic layer to the process and further complicate matters. Circa 1985, HCFA (now CMS) gave States the option to manage the MEQC process in-house. The move resulted in the rise of subject matter experts who have a role in the development of corrective measures impacting operations, systems and policy. It has been our experience that in-house staff is more skillful at identifying errors and better educated at researching and articulating the root causes. Additionally, all PERM eligibility review documentation and materials are retained and subject to CMS audits and other external monitoring.

3. (71 FR 50165): CMS' response to treat a SCHIP participant found eligible for Medicaid the same as if ineligible for both programs (that is, the entire payment is improper) does not consider the realities under which the State operates. Existing monitoring activities indicate that this type of error is primarily attributable to the State's eagerness, in response to CMS' encouragement, to deploy simplification strategies throughout the eligibility process for the purpose of achieving higher program participation levels. At a minimum, this type of error deserves a footnote when included in the State statistics.

4. (71 FR 51072): The estimates ($42,348 per program) States must absorb for furnishing claims information to the federal contractor exclude the costs associated with providing them with training and technical assistance. The real costs are unknown, but higher than estimated.

5. (71 FR 51073): Regarding the tracking of State PERM costs; although not adopted by CMS, it would be prudent for States to track their PERM costs.