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North Carolina
Department of Health and Human Services
Division of Medical Assistance
Program Integrity
2501 Mail Service Center - Raleigh, N.C. 27699-2501
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L.Allen Dobson, Jr., M.D., Assistant Secretary
for Health Policy and Medical Assistance
Lynne Testa, Assistant Director

September 25, 2006

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

Attention: CMS-6026-IFC2

VIA EXPRESS MAIL SERVICE

Re: Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement

Dear Sir/Madam:

North Carolina respectfully submits this comment letter on the Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement. North Carolina is commenting on the notice published in the August 28, 2006, *Federal Register* (42 CFR Parts 431 and 457) for the Centers for Medicare & Medicaid Services (CMS).

We appreciate that CMS has addressed in the August 28, 2006 notice many of the comments that were submitted based on the interim final rule and Supporting Statement published on this subject on May 26, 2006. North Carolina appreciates the opportunity to submit additional comments and questions in the final development of the PERM requirements since implementation will have significant impact on states. We are submitting the following comments detailing additional concerns and requesting clarification on the following issues:

- Continued collaboration with the states in the implementation of PERM;

- Clarification regarding the Centers for Medicare & Medicaid Services (CMS) decision to mandate a state-level error rate measurement system. It is our understanding that the "Improper Payments Information Act (IPIA) of 2002" did not require state-level error rates.

- Clarification on the eligibility component of PERM reviews, including an explanation of the process and requirements for conducting eligibility reviews;

- Duplication of effort issues with regard to operating MEQC and the PERM eligibility review processes.

North Carolina believes the interim final rule does not contain adequate information and clarification to evaluate the impact of and the means for implementation of the PERM requirements on states, especially with regard to conducting eligibility reviews in both Medicaid and SCHIP in the same year as well as continuing the required MEQC provisions. Nor, in our opinion, has consideration been given to "waive" PERM claim review requirements for those states that currently have efforts underway to measure improper payments. Since 1997, North Carolina has measured improper payments in conjunction with our State Auditors Office. We believe the PERM claim review process duplicates work already underway in this state.

Background

- The eligibility workgroup provided CMS with valuable input into the development of the PERM requirements. We believe this continued collaboration with states will provide consistency in the implementation of a review process that will provide valid and consistent information in determining error rates.

- Based on previous comments from states, CMS incorporated some important changes to the Payment Error Rate Measurement program to make the process less burdensome on the states. These changes include: engaging federal contractors to review State Medicaid and SCHIP FFS and managed care payments and to calculate the State-specific and national error rates for both programs; creation of a difference-resolution process; exclusion from the universe Medicaid recipients who receive SSI and Title IV-E foster case assistance and recipients under active fraud investigation; defining the review month as the most recent determination of eligibility providing the last action is within 12 months.

PERM Sampling, IT Data Issues

- When can Year 2 states expect to receive additional guidance and/or information from CMS or the Lewin Group regarding the data elements that will be required for submission (e.g., file formats)?

- States need additional flexibility with provider initiated adjustments or planned agency adjustments. If claims processed at the end of the quarter are sampled, any actions or adjustments may not occur until next quarter. This could create additional manual work updating sampled claims or, worse, increase false positive rates if not factored into the contractor's review. If a claim is sampled that is a reversal of a prior claim, will states need to provide the original claim, even if claim had been paid in a previous time frame? Adopting a mandatory window of 60 days for any and all adjustments is contrary to the time periods allowed in this state.

- Has any additional consideration been given to "dropping" provider claims from the PERM sample that are related to ongoing state or Medicaid Fraud Control Unit investigations? In our opinion, failure to do so may compromise ongoing investigations.

Integrated PERM Timelines for both Claim & Eligibility Review Processes

- As the PERM claim and eligibility processes will be implemented effective October 1, 2006, it would be helpful if states could receive an integrated timeline of contractor and state responsibilities/requirements for both review types.

Eligibility Reviews

- The interim final rule addresses the eligibility process in which eligibility reviews will be conducted using a review process designed to "minimize the effect on States regarding cost and burden" and States will be provided with implementation guidelines. CMS is urged to provide these guidelines to states immediately in order to allow states sufficient time to prepare and implement the necessary procedures to meet the PERM requirements.

  The interim final rule requires Year 2 states to submit a sampling plan by November 15, 2006 and approval must be received prior to implementation. States are requesting sufficient time to prepare and implement the necessary procedures and processes to meet the PERM requirements. If sampling plans are due by November 15, 2006 and approval must be received prior to implementation, states should be allowed to begin the 12-month sample period no earlier than the month following receipt of approval of the sampling plan and use that as the first review month in order to remain current in the process.

- The interim final rule addresses the sample for active cases as being divided into three strata: Stratum 1 will include applications approved in the sample month; Stratum 2 will include redeterminations in the sample month; Stratum 3 will include all other cases. CMS is urged to provide clarification of what constitutes a completed application for stratum 1 and what constitutes a completed redetermination for stratum 2. That is, should applications that are opened as an administrative application, such as a reopening following an appeal reversal, be included in the universe for stratum 1. In addition, reapplications are reopened

cases following a termination action with no break in Medicaid coverage. Would these cases be included in the universe for stratum 1 as a completed application or stratum 2 as a completed redetermination?

- The Supporting Statement that was issued with the interim final on May 26, 2006 reads that states will attach payments for services received in the first 30 days of eligibility for cases in strata one and two and within the sample month for cases in strata three. Many providers do not bill immediately; therefore, many Medicaid services received in the first 30 days will not be billed until a subsequent month. States need additional guidance in the requirements for the payment review of the eligibility cases and the process to follow in determining the payment error rate. CMS is requested to provide additional guidance in the length of time states are permitted to obtain this information. In addition, how will cases be treated with no paid claims for the sample month?

- States are allowed to exclude from the universe cases under "active fraud investigation." The criteria needs to be outlined for what constitutes an "active fraud investigation" in determining when to correctly exclude these cases from the universe or the sample.

- We request clarification on how states are to handle cases that are not subject to review or cannot be completed due to non-cooperation of the recipient or collateral contact or otherwise not completed. For the size requirement of 501 active cases for eligibility for each program, does this require the completion of 501 reviews or only the selection of 501 cases in the sample as there may be cases that will be reported as "undetermined?"

- In addition, clarification is requested regarding the verifications that will be acceptable and any differences from verification requirements in traditional MEQC for cases that are reported as "undetermined." At what point in the review process would a review be reported as "undetermined" and the extent of documentation that is needed prior to reporting a review as "undetermined?"

Duplication of Effort

- CMS appears to be very committed to the collection of information that minimizes any duplication of effort and reduces cost and burden for all states. Based on the comments and responses in the interim final rule, it was agreed that a duplication of effort should be minimized as much as possible; however, MEQC statutory requirements could not be waived and states would not be allowed substitution of PERM eligibility reviews for the MEQC reviews. CMS is requested to consider allowing this substitution based on the states' staffing burden and costs of operating two eligibility systems. We ask that CMS strongly consider allowing this substitution as states will be struggling to meet the MEQC requirements as well as assuming the additional burden of the PERM process.

- Based on the requirement that PERM may not be used to replace the MEQC provisions, CMS is requested to consider the fact that there is the chance that some cases could be selected in the PERM sample as well as the MEQC sample. Therefore, if errors are found in these cases, they would be reported for both MEQC and PERM.

- The Supporting Statement issued with the interim final rule of May 26, 2006 regarding duplication of efforts reported "at state option and upon CMS approval, the MEQC traditional reviews can be considered as meeting the Payment Error Rate Measurement (PERM) eligibility requirements for Medicaid if the MEQC reviews meet the PERM sampling , review and error rate requirements." The interim final rule of August 28, 2006 reports that the MEQC statutory requirements cannot be waived and substitute the PERM eligibility reviews for the MEQC reviews. Due to concerns regarding duplication of effort and cost, this is still under consideration. The Supporting Statement and the interim final rule of August 28, 2006 appear to address different options. Is consideration by CMS for allowing traditional MEQC as meeting PERM eligibility requirements or is the consideration for substituting the PERM eligibility reviews for the MEQC reviews?

- In order to reduce the staffing burden on states, North Carolina urges CMS to reconsider the requirement to have states conduct eligibility reviews for Medicaid and SCHIP in same year. The response in the interim final rule is that by combining both programs in the same year would reduce administrative complexities, costs and burdens since states could combine staff and resources for both reviews. As with other states, North Carolina will be using the same

  staff to conduct the PERM reviews as well as regular MEQC requirements. Since North Carolina has no separate staff to provide program integrity activities for SCHIP, the requirement for PERM eligibility reviews for both programs in the same year will result in a significant burden on our state as far as staffing and available resources to complete the requirements.

Burden Estimate

- CMS has provided the burden estimate on states which has been revised from previous estimates. However, we continue to believe these estimates do not adequately reflect the burden that states must assume in the PERM review process. It appears that states will need to hire and train additional staff to meet the PERM requirements. We urge CMS to further revise estimates to reflect the need to hire and train additional staff, travel required to complete the reviews, and the complexity of certain types of reviews that will require additional time to complete.

- The interim final rule addresses concerns regarding staffing needs for the PERM reviews. Even though PERM is conducted only once every three years, the

process to complete the PERM cycle will take 23 months to complete. CMS must consider that even though the entire process may take 23 months from onset to completion that different staff will be required to complete different phases of the process. The same staff used to provide information for the fee-for-service and managed care components of the program will not be the same staff as completing the eligibility component.

- North Carolina is a state with a two-year legislative cycle. Budget requests for additional staff must be made far in advance. With notification of states in advance of the review cycle, states will be able to prepare better for future years. However, the Year 2 states are at a disadvantage in not having time to predict staffing needs, hire and train qualified staff. CMS is requested to take this into consideration when establishing timeframes for submission of sample lists and reporting of findings for the states that will begin the PERM process in FFY 2007.

Miscellaneous

- CMS is urged to continue to provide states with prompt notification and clarifications as implementation procedures are finalized, including deadlines and expectations for states. We request the CMS develop some means of informing states regarding the details of their responsibilities in the process, including timelines and completion expectations. This communication would allow the states to more efficiently implement the PERM requirements.

- Since Year 2 states are trying to access the impact of PERM on staffing and resources, CMS is encouraged to notify states as soon as possible of the eligibility methodology and allow sufficient time for the states to prepare and implement this burdensome process, especially if the states are not allowed to use PERM reviews to meet MEQC requirements.

Thank you for considering our comments. If you have any questions, please do not hesitate to contact me or Elizabeth Goss at (919) 647-8000.

Sincerely,

Lynne Testa

Lynne Testa
Assistant Director

Cc: Mark T. Benton
Elizabeth Goss

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Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin
Department of Health and Family Services

SEP 25 2006

DIVISION OF HEALTH CARE FINANCING
1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 888-692-1402
dhfs.wisconsin.gov

September 25, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-6026-IFC2
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

The Wisconsin Department of Health and Family Services respectfully submits the following comments about the Interim Final Rule for Medicaid and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement. The Interim Final Rule was published by the Centers for Medicare and Medicaid Services (CMS) in the August 28, 2006 edition of the Federal Register.

Comments Related to Claims and Medical Reviews:

Crossover Claims
Page 51053 of the Federal Register states: "Each selected FFS claim will be subjected to a medical and data processing review." This statement contradicts previous Federal register information and PAM/PERM pilot guidance on medical reviews for crossover claims which indicated that it would not be required. Please clarify the status of this issue since conflicting directions have been published.

Medical Records
In regard to Medical reviews (Section 5 (b)), page 51060: "States will be able to obtain information identifying which providers have not submitted the requested medical records within the first 45 days of the initial request from the DDC." Please clarify whether it is a State responsibility to pursue this issue with the DDC or if the DDC will provide this automatically to the State at the appropriate time. If it is a State responsibility, then CMS will need to require the DDC to keep each State informed of record requests so they will know when the appropriate amount of time has passed and they can make this request to the DDC.

Difference Resolution Process
CMS has stated on page 51061: "The RC will make the documentation on which the decision was based available to the states." We ask that the RC be required to provide <u>all</u> the documentation they received for the case, not just the part of it which they used to make their decision. Without access to the complete information received, states are not able to adequately evaluate the situation and the RC's decision on the case. Provision of a partial record by the RC

for the review part of the difference resolution process is skewing the process to potentially favor the RC's decision.

It is stated in Section IV, item 3, page 51076: "However, for CMS to review the claim, the difference in findings must be in the amount of $100 or greater." Based on PERM pilot experience, the only errors which might meet this limit were ones that did not have a medical record sent in by the provider or a few of the eligibility cases. Additionally, Q1 and Q2 samples for FY 2006 reviews demonstrate that this limit would exclude between 50 and 65% of the claims from a potential CMS review since they were paid at less than $100.

The information on the difference resolution process steps is a start, but more specific information is needed in order to fully evaluate it. Based on the two comments noted above, there is already the possibility to limit the effectiveness of the process by not including all the information the RC received with the State and excluding reviews with differences under an arbitrary amount of $100.

Another potential concern is whether there are any time limits or restrictions placed on this process. None are mentioned other than the RC will provide a report at least monthly unless it is toward the end of the review period when they will increase the frequency. While no State time requirements were listed, if present, the State may be in a difficult position to have enough time to review the cases on the report, especially if the RC is behind in their reviews and consolidates the majority of errors on reports that are toward the end of the review period to meet their deadline.

Recovery of Overpayments
Section 3 (d), page 51067 states: "For claims where error findings stand, the State must recover the overpayment from the provider..." It appears that the statistical contractor is using the performing provider as the sampling unit. In some situations, the performing provider is an employee of the billing provider and no payments are made directly to them. If states are expected to recover overpayments, it would make more sense to use the billing provider as the sampling unit rather than the performing provider. This would ensure that the appropriate entity is aware of the issue from the start and is able to return a potential overpayment since they initially received it, not the person who performed the service.

Comments about Eligibility Reviews:

Agency Responsible for Eligibility Reviews
It is stated on page 51064 in Section C, item 1, (a) that CMS will require the agency conducting the PERM eligibility reviews to be "functionally and physically separate and independent from the State agency responsible for the Medicaid and SCHIP policy and operations, including eligibility determinations." We believe this regulation would limit State flexibility and unnecessarily increase the complexity and cost of PERM administration.

It is our understanding that, in most states, State employees who are not physically and functionally separated from the State agency responsible for eligibility policy and operations are currently performing Medicaid Eligibility Quality Control (MEQC) activities. There is no

evidence provided to support the assertion that the current organizational structure presents a conflict of interest for MEQC.

Wisconsin's MEQC resources are not involved in eligibility determinations, but are physically and functionally integrated into the State agency responsible for eligibility policy and operations. As such, they possess the expertise to accurately perform eligibility reviews and conduct trend analysis for program evaluation and improvement. Employees who possess thorough knowledge of eligibility policy and operations matters are in the best position to identify program improvement opportunities and contribute toward the implementation of corrective action initiatives. We are confident that MEQC review findings and error rate calculations are accurate and objective. Placing restrictions on the resources states can use to comply with PERM eligibility requirements will unnecessarily increase the complexity and cost of administration.

Further, it is stated on page 51076 [in Section IV, item 2, (c)] that PERM eligibility reviews must be conducted by a "State" agency that is independent of the State agency making the program eligibility determinations. Requiring a separate "State agency" to conduct the eligibility reviews seems to limit the flexibility of states to contract with private agencies or to reallocate existing resources in order to meet the PERM requirements. This is especially problematic considering the short notice provided about the State rotation schedule. While we understand that CMS is unable to provide enhanced funding for states to complete the PERM eligibility review -- to place further administrative requirements on states that will be costly in terms of training staff to be competent at the level required to complete accurate reviews and remain current on all policy and process changes, with the additional administrative cost of a separate State agency, is unreasonable.

Administrative Period

CMS states on page 51064 in Section C, item 1, (c) that the administrative period is not applicable when the focus of review is the month of application, re-determination or most recent State action. State and Federal policies related to prospective budgeting, change reporting and advanced notice should be reflected in the eligibility review methodology. If income is prospectively budgeted correctly, we disagree that an eligibility error should be cited based on verified actual circumstances during the month of application, re-determination or most recent State action.

In the FFY 2005 PERM Pilot, states were required to determine the accuracy of eligibility based on actual case circumstances as of the claim date, without consideration for reporting and notice requirements. As the pilot demonstrated, unexpected changes which impact eligibility can and do occur after eligibility has been confirmed, even within the month of application, re-determination or after another change has been reported and acted upon. Errors attributed to "administrative period" had a significant impact on Wisconsin's final error rate during the PERM Pilot; in fact, our error rate was negatively impacted by 4.05%. Therefore, it is our contention that the administrative period concept is indeed applicable if states are required to determine the accuracy of the eligibility determination based on actual case circumstances in the review month, without consideration of applicable State and Federal policies.

Burden Estimate
Based on our experience with MEQC and the FFY 2005 PERM Pilot, it is our opinion that the estimates stated on page 51068 (in Section E, item 1, (b)), are understated. CMS acknowledges that the estimates were based solely on the PAM/PERM pilots, and do not take the expanded scope of PERM into consideration.

Further, on page 51069 in Section E, item 1, (b), CMS asserts that states were given sufficient time to receive budgetary approval for staff resources. We respectfully disagree since a rotation schedule was not published until August 28, 2006, and most states operate on a biennial budget cycle. Wisconsin's biennial budget request for the State fiscal years of 2007-2009 had already been prepared prior to the release of the Federal Register notice. Procurement of trained resources necessary to complete PERM eligibility reviews could present a challenge, especially if the reviews are required to be conducted by a State agency that is physically and functionally separate from the State agency responsible for policy and operations.

Case Reviews
CMS provides estimates on page 51074 in Section IV, item 2, (b) that a State's annual sample size will be approximately 501 active and 200 negative case reviews for each program. It is also implied that some states will have a sample requirement more or less than the estimated number, in order to achieve the required 3% precision level at a 95% confidence interval level. For obvious reasons, specific information about the number of required eligibility reviews is needed for resource planning. Will states be required to independently determine the number of reviews required to achieve the desired precision level, or will CMS' statistical Federal contractor determine these figures?

Eligibility Review Process Details
On page 51076, in Section IV, item 2, (c), CMS indicates that verification of eligibility can be established primarily through desk review of case records, although there are instances when states would be required to verify information (for example, information missing from the file, outdated or likely to change). Specific information about verification requirements is needed to fully assess the impact of the eligibility review requirements. In order to ensure uniformity in the eligibility reviews, CMS will need to provide a specific definition of "outdated" and "likely to change."

It is also unclear whether the sampling unit is an "individual" or "case." Will states be required to review the eligibility of all beneficiaries within a case or the eligibility of one selected individual beneficiary within a case? There are references to a "case-based methodology" (page 51065), "individual beneficiaries" (page 51074), and "individual beneficiary cases" (page 51075). Clarification is necessary to develop accurate resource estimates.

Review Methodology - Relationship between SCHIP and Medicaid Eligibility
CMS indicated in Section C, item 1, (c), page 51065, "If a State erroneously determines a person eligible for Medicaid, the payments for the Medicaid services made by the State are improper regardless of whether the eligibility determination was made as of a SCHIP application or a Medicaid application." Additionally, it is stated in Section IV, item 2 (c), that, "for all SCHIP

cases, the reviewer will further verify that the case is not eligible for Medicaid by following the SCHIP requirements at 42 CFR 457.350 to screen SCHIP applicants for Medicaid eligibility."

In Wisconsin, eligibility is determined for both Medicaid and SCHIP within an integrated eligibility system and a request for health care coverage is considered an application for Medicaid or SCHIP. Further, full benefit Medicaid or SCHIP Wisconsin beneficiaries are eligible for the exact same health care coverage package. Therefore, it is our assertion that payments made for SCHIP recipients who, through PERM review are determined ineligible for SCHIP but eligible for Medicaid, should not be considered totally erroneous.

If a recipient is determined to have been ineligible for SCHIP for a reason such as access to employer paid private health insurance, but has countable income that does not exceed Medicaid program limits, the recipient was not ineligible for health care coverage. We therefore contend that the actual amount of erroneous payment in this example is merely the difference in rate of federal financial participation, rather than the entire SCHIP claim.

Conversely, if a recipient is determined ineligible for Medicaid for a reason such as excess income but would have qualified for SCHIP, the recipient was not truly ineligible for health care coverage. The precise error amount in this circumstance is actually just the underpayment to the State in federal financial participation, rather than the entire Medicaid claim.

Data Collection and Error Rate Calculation

As in the PERM Pilots, will CMS provide states with an eligibility data collection system to ensure uniformity in the error rate calculation? We believe that a data collection system designed by CMS will promote accurate reporting throughout the PERM review process. If each State is responsible for development of a data collection system, there will be increased costs and potential for inconsistency.

In closing, we would like to thank CMS for its efforts to obtain feedback from State agencies and other interested parties on this important regulation. We remain committed in our effort to achieve payment accuracy and encourage you to contact us if we can provide any additional information.

With warm regards,

Kevin R. Hayden
Administrator

KRH:dd
BE09014

bcc: Alan White
Jim Jones
Lori Thornton
Joanne Simpson
Brian Fangmeier
Vicki Jessup

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New York State
Office of the Medicaid Inspector General
Riverview Center
150 Broadway
Albany, NY 12204

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

September 21, 2006

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

Attention: CMS-6026-IFC2

Re: File Code CMS-6026-IFC2

To Whom It May Concern:

In reference to the Department of Health and Human Services' interim final rule on Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement (PERM), New York submits the following comments.

Payment Error Rates and Eligibility

We thank the Centers for Medicare and Medicaid Services (CMS) for the progress made in reducing the cost and burden to the states in conducting the medical and data processing reviews on fee for service and managed care claims. CMS indicates in the interim final rule that states will be reimbursed for their work on the eligibility measurement portion of PERM at the applicable administrative Federal match under Medicaid and SCHIP.

Previous CMS communications suggested that states may be provided the option to use the PERM reviews to satisfy Medicaid Eligibility Quality Control (MEQC) requirements under 1903 (u) of the Social Security Act. Allowed this option, states' additional expenses in complying with the requirements of PERM would be reduced. However, CMS now indicates that analysis of the associated legal and policy matters regarding this option are not complete and, as a result, states may not be able to use the PERM reviews to satisfy MEQC statutory and regulatory requirements. Given this, if CMS does not allow such substitution without disallowances of Federal funds, we believe that states should be reimbursed in full for the PERM eligibility functions which,

by CMS' own admission, is duplicative of MEQC.

In response to concerns expressed about the burden and costs to states to perform the eligibility measurement, CMS indicates that the responsibilities will not significantly impact the states. However, since CMS has not made a final determination regarding the substitution of MEQC review for the PERM eligibility review, and is now requiring the PERM eligibility reviews be conducted by a "*State agency independent of the State agency responsible for Medicaid and SCHIP policy and operations, including making the program eligibility determinations*", any economies of scale have been eliminated. In fact, states may have to establish eligibility review functionality in a "new" entity in the State where staff and expertise do not exist. This will have significant infrastructure costs both in personnel and non personnel expenditures. This requirement is not required in either Food Stamps or TANF, and should not be required in Medicaid. If CMS feels the PERM eligibility review staff must be in a "unit" separate from the eligibility policy staff, that could be supported. However, requiring the staff be outside the Agency responsible for eligibility will not only be costly, but will make it nearly impossible to ensure that the staff remain current with eligibility requirements and processes.

For SCHIP, Health Plans conduct the enrollment and determine eligibility according to State policy. The way the program is structured, the State SCHIP office is an independent entity in reviewing eligibility. This office currently audits each Plan annually. As such, we believe the SCHIP Audit Unit, which is separate from the Policy Development and Operations Unit, should be able to carry out the eligibility reviews under PERM. Establishing a separate group in a different agency would be duplicative of the current state oversight role and again, make it nearly impossible to ensure the staff remain current with eligibility rules.

Use of National Contractors

We applaud CMS for adopting commenters' recommendation to engage National Contractors to estimate components of the improper payment measurement. We also believe that CMS has attempted to select contractors with appropriate experience. Despite these efforts, we do not believe that the contractors have the required and extensive knowledge held by the states, and will not be able to garner that knowledge in time to complete the reviews as currently scheduled by CMS. To that end, we believe that time must be built into the PERM process to allow for such knowledge transfer.

The States must provide all adjudicated FFS and managed care claims information from the review year, on a quarterly basis, with FFS claims stratified by type of service. This stratification places an additional burden on the States, which should be done by the Federal contractor, not the States. Stratification of quarterly claims data by individual States could also result in errors and inconsistencies between State PERM estimates. We encourage CMS to have the Federal contractor conduct the quarterly claims stratification to ensure consistency across States and from quarter to quarter.

Collection of Information-State's Role

We agree with commenters who suggested that it would be difficult for states to obtain approval for additional staff when PERM activities occur only once every three years.

The CMS response to this issue: "Since the Federal contractors will conduct the reviews for managed care and FFS, the selected State will only provide the required State policies and claims information, technical assistance on the State's program, and the State's corrective action plan to reduce improper payments." We feel that there are additional State responsibilities that were not included in the CMS response and the estimate of cost and burden. These additional responsibilities include:

- Retrieving records that the contractor cannot retrieve after 45 days
- Reviewing the monthly disposition report from the RC for determinations of the medical and data processing reviews for each sampled claim
- Working with the RC to resolve differences in findings
- Filing a written disagreement with findings to the RC
- Providing technical assistance to the contractor performing the data processing reviews
- Reviewing quarterly claims sample for any adjustments made to the sampled claims and sending to the contractor
- Reviewing error rates and determining the root causes of error-prone cases prior to developing the corrective action plan
- Monitoring implemented corrective actions to determine whether the actions are effective and whether milestones are being reached
- Evaluating the corrective action plan – may discontinue corrective actions that are determined to be ineffective and implement new actions
- Recovering overpayments from providers for claims with error findings

CMS further states they believe the submission of information will not require experts or experienced staff since the information that CMS is requesting (for example, State medical policies and updates) should be available in-house for State submission.

Medicaid does not have one set of program guidelines. Each State has options as to the services it will cover, the policy guidelines that will be in force, the levels of reimbursement, the documentation standards, etc. Each State relies on their statutes

and administrative rules to define the general rules and parameters of these policies, and then each State produces volumes of materials, including manuals, updates, bulletins, provider letters, etc., that refine and explain its policies and procedures. It will be necessary to have experienced staff providing information to the contractor, as State staff must be thoroughly familiar with Medicaid rules, regulations, policies and guidelines in order to provide the appropriate material and technical assistance to the contractor. In addition, if there is a need for additional follow-up information, staff must be able to locate the appropriate information or know where to obtain the information.

CMS states that in order to allow for timely completion of the error rate estimates, only adjustments made to claims within 60 days of adjustment or payment will be considered in the error rate calculation.

States will need to track the sample claims for any adjustments and inform the Federal contractor of any changes in adjudication. Since States have varying time periods for claim adjustments, 60 days is a very short timeframe to have any claim adjustments for sampled claims. By allowing only 60 days for adjustments, many claims may be counted as an error that will be later adjusted and paid after the 60 day period. These 'error' payments have to be recovered by the State, so the States could be recovering an error payment that was later adjusted and paid appropriately.

Medical Reviews

The Documentation/Database Contractor (DDC) collects and stores State medical and other related policies, and requests the medical records from providers for the FFS medical reviews. In PAM pilots, many of the errors were due to incomplete or missing documentation. We appreciate that the contractor will make several attempts (3 letters and 3 telephone calls) to retrieve medical records. However, it is imperative that when the contractor receives medical records from the provider, they immediately review for completeness and appropriateness of documentation. Experience in the PAM pilots has shown that even though the provider may submit documentation, what is received needs to be reviewed as soon as it arrives to ensure completeness and appropriateness. This should not wait until the medical review actually occurs. If this is not done and the MR has incomplete medical records, this will result in determining the claim an error. At this point of review, it may be too late to obtain complete provider records or to clarify and resolve other documentation problems with providers.

The assurances CMS establishes relative to receipt of documentation from providers before considering an error for lack of medical documentation is insufficient. Nationally, Medicaid programs are challenged to enroll sufficient numbers of qualified practitioners into their programs. Paperwork requirements are often daunting and are often cited as the reason providers do not enroll in Medicaid programs. To that end, it is unreasonable to suggest that providers will respond timely to three written and oral requests during a 90 day time period. We believe that states can and will make every effort to work with providers relative to compliance on the issue of providing documentation to the Federal contractor. However, states' years of experiences in this area clearly prove that providers are slow to comply with requests for information, in

many instances for the reasons noted above. This delay in providers' compliance can not and should not be ignored. As a result, we believe that the Federal contractor should be required to continue, with State support as necessary, to obtain needed documentation throughout the entire review year.

Payment Error Rate and Eligibility Reporting and Appeals

CMS has rejected "standard" auditing protocols which would allow states the opportunity to review the draft PERM report, and have an opportunity to resolve disputes and make comments/respond within a reasonable timeframe (30 days). CMS cites that states are part of the process and have opportunity to provide input during the entire measurement process. In addition, the difference resolution process is cited as a means for states to resolve disputes with the Federal contractor. We appreciate the steps CMS has taken to provide states with input all along the process. However, it is not clear that all differences can be addressed by the dispute resolution process, nor does there appear to be a process to capture unresolved differences in the final report. To that end, we seek such opportunities from CMS.

CMS indicates that summary eligibility findings on all case reviews are to be submitted by July 1 following the fiscal year under review. This means that monthly reporting is not required?

Medicaid Revisions for Erroneous Medicaid Eligibility Determinations

Pursuant to section 431.1002 of the interim final regulations, payments based on erroneous eligibility determinations are addressed under section 1903 (u) of the Act. This appears to conflict with the statement on page 51065 that states ..."there are no adverse consequences associated with eligibility error rate computations under the IPIA." Please explain this contradiction.

Applicability of Administrative Period for Determining the Amount of Improper Payments for Eligibility Errors

We concur that the administrative period is not applicable to stratum 1 (approved applications); however, the administrative period should be applied to stratum 2 (redeterminations) and stratum 3 (all other cases). "The amount of improper payments is the amount paid improperly for services received.....in the review month (the month of redetermination or last action taken by the State within 12 months of the month the case is sampled) or during the sample month (for cases in stratum three)." Pursuant to federal timely notice requirements, any reduction in Medicaid coverage, such as a reduction from full coverage to coverage with a spenddown, may not occur until the month following the month of the redetermination; given this, the administrative period must be applied. Similarly, the administrative period must be applied to stratum 3 cases which are also subject to the timely notice requirements for reductions in Medicaid coverage.

CMS has instructed states that a recipient may not be terminated from Medicaid without first determining if the individual is eligible for assistance in any other Medicaid category (referred to by CMS as an ex parte determination). In New York, there are no less than 20 Medicaid categories of assistance, exclusive of persons who receive Medicaid as a result of their eligibility for cash assistance, with countless potential household combinations in each category. The eligibility requirements of the categories are not mutually exclusive and as a result, such ex parte determination may require receipt of additional information, such as medical information to make a determination of disability, before a conclusion about continued eligibility can be reached. Requiring states to continue eligibility while conducting a review to assure the individual continues to be eligible for assistance is tantamount to requiring an administrative period while putting the state at full risk of liability for the extended coverage. We urge CMS to reconsider potential conflicts in its programmatic requirements and allow an administrative period for stratums two and three cases.

We thank you for the opportunity to comment on these regulations. If you have any questions or wish to discuss our comments further, please feel free to contact Linda LeClair at 518-474-8887.

Sincerely,

Kimberly A. O'Connor
Medicaid Inspector General

Brian J. Wing
Deputy Commissioner
Office of Medicaid Management

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov
Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

BOB RILEY
Governor

CAROL A. HERRMANN-STECKEL, MPH
Commissioner

4

September 19, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC2
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

The Alabama Medicaid Agency respectfully submits this comment letter on Medicaid and SCHIP Payment Error Rate Measurement (PERM). Alabama Medicaid is commenting on the interim final rule proposed published in the August 28, 2006, *Federal Register* (71 *FR* 51050) for the Centers for Medicare and Medicaid Services (CMS).

Alabama Medicaid was encouraged that CMS went into more detail explaining each component of PERM. However, as discussed in our comment below, we believe that there remains one confusing issue involving the Cost and Burden, Methodology and Eligibility within their respective sections where states simply lack sufficient information to fully evaluate CMS' PERM eligibility plans. Specifically, there is conflicting information in the interim final rule as to who will be able to conduct the eligibility reviews. In turn, without such information, we believe CMS has underestimated the burden to states to comply with PERM.

Our specific comments, as it relates to each section, are as follows:

III. Analysis of and Responses to Public Comments
C. *Expanded FY 2007 Error Rate Measurements*
1. Eligibility
a. Cost and Burden

The last comment under this area states that the PERM rule should address the organizational structures that are applicable for conducting the PERM eligibility reviews. Since PERM identifies improper payments, the commenter believed that a possible conflict of interest may occur if a Quality Control (QC) Unit is contained within a Medicaid Policy Office or Division. CMS' response was 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.

In regards to this issue, Alabama Medicaid seeks clarification of the intent of CMS' response to the comments made under the Cost and Burden. The commenter under the Cost and Burden area clearly stated that the concern was with the QC Unit being a part of the same office or division, not the same agency.

c. Methodology

The first comment under this area states that having a contractor conduct the eligibility review raises confidentiality issues both in State and Federal law concerning Social Security Administration and Internal Revenue Service information in the case records. CMS responded by stating that they believe the concerns are addressed by having the States rather than the Federal contractor conduct the review.

In regards to this issue, Alabama Medicaid seeks clarification on who can conduct the eligibility reviews, state staff or contracted vendors. If CMS intent is for the state agency to contract with an outside vendor to conduct the PERM eligibility reviews, then Alabama Medicaid suggests that the eligibility component of PERM should be delayed until April or May 2007, to allow time for the states to develop and implement the necessary contractual arrangements.

IV. Provisions of This Interim Final Regulation
2. Eligibility

Bullet 8 states that in comments regarding conflict of interest, CMS provides 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, is functionally and physically separate) including making the program eligibility determinations.

In regards to this issue, Alabama Medicaid seeks clarification on who can conduct the eligibility reviews, state staff or contracted vendors. If CMS intent is for the state agency to contract with an outside vendor to conduct the PERM eligibility reviews, then Alabama Medicaid suggests that the eligibility component of PERM be delayed until April or May 2007, as stated above.

In an effort to gain clarification of CMS' intent, state staff contacted Janet Reichert of CMS. Staff explained that the Alabama Medicaid Agency has an Eligibility division that is responsible for setting policy and determining eligibility and also has a Program Integrity division that conducts QC reviews. Although these two divisions are within the Medicaid Agency, they are separate and independent of each other and report to different Deputy Commissioners. Ms. Reichert stated that based on the information given to her that Alabama Medicaid would meet the regulatory requirement. However, she did state that without actually seeing the organizational structure of the Alabama Medicaid Agency she could not give a definitive answer. We are requesting that CMS give a clear, concise and definitive answer to this issue.

The regulation seems to require that separate state agencies be used, while the verbal guidance we have received indicates that use of separate, independent divisions within the Medicaid Agency is acceptable.

Thank you for allowing us the opportunity to comment. We look forward to your response to our comments.

Sincerely,

Carol A. Herrmann-Steckel, MPH
Commissioner

CAHS:jt

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SEP - 1 2006

August 29, 2006

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

Dear Representative:

In response to your invitation for comments to the interim final rule published in the Federal Register on Monday, August, 28, 2006, I submit my comments related to state estimation of payment error rates due to errors in eligibility determinations.

I request that you consider distinguishing within the data collection state estimation of payment error rates for residential care services as opposed to other services. Between 1995 and 2002, national Medicaid waiver-funded residential care participants increased almost threefold and expenditures more than quadrupled to $2.3 billion.[1] Since residential care services often cost significantly more than other services available under the Medicaid program, I request an additional step be added by the agency to perform a quantitative and qualitative measure to not only estimate the payment error rates but determine the underlying reason for the payment errors through surveys. The agency may then utilize the data to correct the errors by supplementing with training where needed. Since the cost of residential services is so significant, a great deal of waste can be eliminated by paying special attention to the payment errors associated with this program.

Thank you for your consideration.

Sincerely,

Robert Waterman
Attorney at Law
11328 Evans Trail
#103
Beltsville, MD 20705

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[1] Kitchener, Martin, Hernandez, Mauro, Ng, Terrence, and Harrington, Charlene (2006). Residential Care Provision in Medicaid Home- and Community- Based Waivers: A National Study to Program Trends. The Gerontologist, 46, No. 2, p. 165-172.

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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

CLARKE 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.

Section IV: Provisions of This Interim Final Regulation

1. (71 FR 50175): Regarding the exclusion of cases denied or terminated for failing to complete the application or re-determination process according to State policy; to remove these cases from review eliminates a valued source of information. These types of cases provide valuable insight into the certifying agency's case processing practices and complaint resolution process.

2. CMS' comment that the positive sample size may vary among participating States in order to meet the PERM statistical requirements is somewhat puzzling and an understatement. Given that the size of the universe influences the sample size, in New Jersey, the positive sample size for Medicaid eligibility reviews has been estimated to be over 700 cases. This would represent a 40% increase in our sample size over the minimum. Also, the PERM stratification requirements are more complex than envisioned and is likely to pose a significant challenge for our systems area. It is our conclusion that CMS cannot properly reflect the cost and burden to States with sample sizes higher than the minimum in its estimates, because it will not have sufficient information before the November 15, 2006 submission date for PERM Sampling Plans.

Section V: Collection of Information Requirements: No Comment

Section VI: Regulatory Impact Statement: No Comment

We hope that our candid comments, questions and recommendations are useful as CMS administrators continue to work toward complying with the IPIA of 2002 requirements. Questions regarding our remarks may be directed to Claude T. Singleton, Bureau of Quality Control at (609) 588 2959.

Sincerely,

Ann Clemency Kohler
Director

ACK: CTS

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC2
P.O. Box 8013
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Comments on Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement Interim Final Rule, 71 *Federal Register* 51050 (August 28, 2006)

To Whom It May Concern:

I am writing to express several concerns that we have about the Interim Final Regulation (IFR) published on August 28, 2006 regarding the Medicaid and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement (PERM) reviews. The regulations, if implemented in their current form, will have significant repercussions for state Medicaid and SCHIP agencies, beginning October 1, 2006, the effective date of the new regulations. We are particularly concerned about the disproportionately burdensome impact that the IFR will have on SCHIP, as CMS has chosen to apply the same requirements to both Medicaid and SCHIP, even though SCHIP is a far smaller program. We are also concerned (1) that PERM may inaccurately inflate eligibility error rates, which may result in some states re-instituting some of the procedural barriers to eligibility that have been broken down over the last decade and (2) that the costs associated with PERM could force some states to reduce coverage of children under SCHIP and/or to cut back on other administrative functions, such as eligibility processing or outreach. A more detailed discussion of our major concerns with the IFR follows.

1. **PERM places a disproportionate and excessive burden on SCHIP.**

   SCHIP covers far fewer individuals than Medicaid, and state SCHIP expenditures represent a fraction of state budgets as compared to Medicaid. Yet, under the August regulation, the smallest SCHIP programs and the largest Medicaid programs will be required to sample about the same number of cases (501 active and 200 negative cases), at an estimated cost of $532,000 per program. This represents a significant amount of money for a program the size of SCHIP, and will have a particularly significant impact on smaller states, states which are close to hitting the 10 percent cap on administrative expenses

and states which may exhaust their SCHIP allotments in the year that they must conduct PERM reviews. A number of states could be forced to serve fewer children and/or to cut back on other important administrative functions, such as process applications, outreach and quality improvement because of the new PERM requirements.

Therefore, CMS should not implement the PERM eligibility reviews called for in the latest interim final regulations for SCHIP in FY 2007. Instead, CMS should convene a workgroup composed of all stakeholders – including Federal officials, state SCHIP directors and children's advocates – in order to develop an alternative methodology tailored more appropriately to the SCHIP program.

2. **The PERM methodology may inaccurately inflate payment error rates in both Medicaid and SCHIP, leading states to impose new procedural barriers to enrollment or renewal.**

The IFR is unclear on how PERM eligibility determinations are to be made, and we are concerned that this ambiguity could inaccurately inflate payment error rates. We understand that CMS is also preparing more detailed instructions about PERM, without public comment or input. CMS should clarify that PERM reviewers are not required to consult information sources other than those that the state itself had to consult in making the underlying determination. Thus, if a state's verification and other procedural requirements comply with federal law and the eligibility caseworker complied with state procedures, PERM reviewers should not be required to independently verify information upon which the state's determination was made. Otherwise, estimated errors will be overstated and states may feel compelled to implement more restrictive procedural requirements – thereby resurrecting barriers to the enrollment of eligible individuals which advocates and states have worked hard to eliminate over the years.

CMS also should clarify that PERM reviews will not immediately encompass state compliance with significant changes in federal rules or policies. For example, the Deficit Reduction Act of 2005 created new Medicaid citizenship documentation requirements, which just went into effect this past July 1. Moreover, CMS policy implementing the new documentation requirements is not completely settled. While interim final regulations on citizenship documentation were issued on July 12, CMS has said it will be issuing final regulations (which may differ from the interim regulations in as yet unknown ways) in the near future. The new and uncertain nature of the new rules will make it extremely difficult for states to be in full compliance in FY 2007. Therefore, CMS should

exempt new federal rules from the scope of PERM eligibility reviews until states have had a reasonable opportunity to implement the new rules. In this case, the FY 2007 PERM reviews should not encompass the Medicaid citizenship documentation requirements.

CMS should allow for findings of "undetermined" for the medical claims reviews, just as it permits for the eligibility reviews. Under the current IFR, if the PERM reviewer cannot collect enough documentation about a fee-for-service claim to fully determine whether a claim was correctly paid, it is automatically considered an error, even if the reviewer lacks proof that an error actually occurred and even if the state had sufficient documentation to properly pay the claim. In the pilot projects that have been completed, the leading source of errors has been insufficient or missing documentation, not demonstrable errors. Failure to recognize an "undetermined" result could produce artificially inflated payment error rates.

Finally, payment errors reported under PERM should only be based on federal funds, not those involving state funds. There is no statutory basis for collecting or reporting data about payment errors involving state funds.

3. **CMS should avoid requiring states to conduct duplicative reviews of Medicaid eligibility errors through PERM and the Quality Control system.**

By law, states already are required to assess eligibility errors through the Medicaid Eligibility Quality Control (MEQC) system. If a state already conducts traditional, statistically based MEQC reviews, it should be able to report those findings in lieu of having to spend additional resources conducting duplicative PERM eligibility reviews.

Sincerely,

Kevin W. Concannon
Director

KWC:as

Bcc: Anita Smith
Shellie Goldman
Ann Wiebers
Gene Gessow
Central Files (Theresa Yourison)

Minnesota Department of **Human Services**

September 26, 2006

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

Attention: CMS-6026-IFC2 [Federal Register Vol. 71, No 166 August 28, 2006

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

To Whom It May Concern:

We are respectfully submitting this comment letter on the interim final rule published in the August 28, 2006, *Federal Register* (71 *FR* 51050) for the Centers for Medicare & Medicaid Services (CMS) pertaining to the Medicaid Program and State Children's Health Insurance Program (S-CHIP) Payment Error Rate Measurement (PERM).

The Minnesota Department of Human Services is fully committed to reducing Medicaid and S-CHIP errors. We recognize and applaud CMS' effort in continuing to dialogue with all of the states in exploring concerns raised during the comment period of this and prior rules. We have listed our remaining comments, concerns and suggestions below for your consideration.

Duplication of efforts: MEQC and PERM

We are encouraged that CMS is continuing to look at the issue of duplication of efforts between MEQC and PERM (MA and S-CHIP) and strongly encourage you to continue to examine this issue. According to the schedule published in the interim final rule, Minnesota will be required to do eligibility reviews in 2009. Minnesota is a MEQC pilot state and submits a MEQC plan annually to CMS. We realize there are different laws governing the two processes and that the PERM eligibility requirement is only once in every three years. To require Minnesota and other states to conduct simultaneous studies for PERM and MEQC will result in states doing eligibility reviews twice every third year. This results in inefficient use of state and federal resources.

We offer the following suggestions:

i) Waive the MEQC requirements for the PERM year.

ii) In the PERM year, allow states to utilize the quarterly sample that was drawn for the record and claims processing reviews for eligibility reviews. This sample will be broken down into the three strata indicated in the interim final rule. Pilot MEQC states can then be allowed to submit these results as their MEQC results with an amended MEQC plan to reflect this methodology. This we believe will meet the requirements of both PERM and MEQC during the PERM years.

iii) CMS could eliminate the stratification of the universe for eligibility and reduce the number of months data is collected to manage the aggregate sample size at the state level. The sampling size may be otherwise prohibitive.

Sampling Parameters for Eligibility Review

Please clarify the sampling parameters states are expected to use to select the monthly samples of the three unique strata of active cases/recipients for the PERM eligibility reviews: (a) confidence interval, (b) confidence level and (c) estimated margin of error. Also please specify the sampling parameters states should use to select the monthly sample of negative cases which are not stratified.

The interim final rule is silent on the question as to what states should do in estimating the margin of error for the sampling size. Clear guidance is warranted. CMS should specify the estimated margin of error states should build into the eligibility review. Otherwise, are we correct in assuming that CMS is allowing states to set their own Margin of Error in their sampling plan?

The interim final rule uses terms such as confidence interval, confidence level, and precision level. The words "interval" and "level" are used differently throughout this and the prior rules. Clarification is needed.

PERM eligibility reviews and the State Medicaid Agency

On page 51064 of the analysis of public comment, one commenter expressed concern about conflicts of interest. CMS responded to this comment on pages 51064 and 51074 that the unit that conducts 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 strongly encourage you to clarify the above statement. In Minnesota, for example, the unit that will conduct the eligibility reviews is located in the same umbrella agency that contains the Medicaid and S-CHIP programs. To require states to establish a separate agency to do eligibility reviews or to relocate the PERM eligibility review unit to another state agency would be problematic and cause undue burden and expense. For purposes of conflict of interest, it should be enough to require that the reviewing unit does not directly report to the Medicaid or S-CHIP program officials, even though it may report to the commissioner of the umbrella agency.

Burden

In the absence of changes to the interim final rule, the following elements produce an unnecessary burden on states:

i) The size of the universe and the size of each stratum, both positive and negative, will be large and the aggregate burden will be excessive.

ii) Stratification will lead to a sample size that is larger than if the universe were not stratified, again creating excessive burden.

iii) The absence of sampling parameters in the final rule is of concern. Prior communications to CMS from both APSHA and Minnesota have addressed the issue of sampling parameters, specifically the estimated margin of error. This issue is again not addressed in the interim final rule. The selection of the margin of error has serious implications for the sample size. Therefore, it is important that CMS provide clear guidance on this issue.

iv) We reiterate that conducting eligibility reviews for PERM MA, PERM SCHIP, MA negatives and MEQC all in one year is an excessive burden which will require a significant increase in staffing and resources.

Additional Issue Regarding Communications

We believe that there should be consistent dialogue between CMS and states to assist in exploring critical issues that come up. We are proposing that CMS staff initiate monthly conference calls between CMS, the Statistical, Document/Database Contractor, Review Contractor, all of their sub-contractors and all states to foster on-going communication between all parties involved with PERM and to facilitate addressing of ongoing concerns and questions as we move forward with PERM. CMS has initiated and continues to successfully conduct such conference calls in other programs.

We thank you for the opportunity to comment on interim final rule pertaining to the measurement of payment error, and for considering our comments. If you have any questions regarding the comments listed above, please contact Christina Baltes, by telephone at 651-431-4279 or by e-mail at christina.baltes@state.mn.us.

Sincerely,

Christine Bronson

Christine Bronson
Medicaid Director

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Health and Recovery Services Administration
PO Box 45502, Olympia WA 98504-5502

September 22, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC2
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

To whom it may concern:

Thank you for this opportunity to comment on the "Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement; Final Rule" CMS notice of interim final rule, published by CMS in the August 28, 2006 edition of the *Federal Register*.

The State of Washington is pleased that CMS has addressed a number of issues and concerns raised in previous comments, and that CMS has consulted with some states regarding eligibility and other issues contained in the interim rule for the PERM project.

The following comments and suggestions provide a more detailed explanation of our concerns and requests for clarification, including:

- CMS should abandon the proposed State-level error rate in favor of a national error rate and sampling plan;
- The ROI resulting from the State's existing payment integrity programs was grossly superior to the PAM ROI;
- The State recommends CMS make the appropriate regulatory changes to allow PERM reviews to substitute for MEQC reviews in years when States are selected to participate in PERM;

- Requiring the State perform eligibility reviews within existing resources will have a significant financial impact on the State;
- The State encourages CMS to reconsider requiring the State agency responsible for the eligibility review to be independent of the State agency responsible for Medicaid and SCHIP policy and operations;
- The state recommends CMS allow Pilot MEQC States to convert to traditional MEQC status in PERM measurement years;
- The State encourages CMS to provide a solution that minimizes duplication of effort related to traditional MEQC and Pilot MEQC review processes;
- Clarification of eligibility sampling processes; and
- Suggestions and clarifications related to CMS response to public comments.

I. Background

- CMS should abandon the proposed State-level error rate in favor of a national error rate and sampling plan.

  We question the CMS's rationale and authority to implement a State-level error rate. The Improper Payments Information Act (IPIA) of 2002 does not require state-level error rates and state specific information is not necessary to support national improper payment measurements. A national sampling framework should be developed to support measurement of a national error rate. CMS should reconsider the necessity and utility of State-level error rates.

- The ROI resulting from the State's existing payment integrity programs was grossly superior to the PAM ROI.

  The State measured overpayment recoveries collected within the State's existing payment integrity programs with revenue collections resulting from PAM, and confirmed that the ROI resulting from the State's existing payment integrity programs was grossly superior to the PAM ROI.

II. Provisions of October 5, 2005 Interim Final Regulations

- CMS should fund 1st cycle eligibility reviews with 100% federal funding.

  Since provisions and regulations regarding eligibility reviews are still under considerations, States have not had sufficient time to plan, budget, and implement the eligibility review component of the PERM project. States selected for PERM projects should be not be required to conduct eligibility reviews until the time such component is fully explicated and necessary resources can be assembled to successfully complete the program.

- Since SCHIP programs were not reviewed by States participating in FY2006 projects, CMS should reconsider the cumulative burden estimates.

  Since SCHIP programs were not reviewed by States participating in FY 2006 projects, the anticipated burden on the States to participate in PERM should be reconsidered. Specifically, the requirement of FFS samples of 1,000 cases AND managed care samples of 500 cases PER PROGRAM substantially increases the amount of information that must be submitted to the Statistical Contractor (SC), the necessity of tracking and reporting adjustments and appeals, as well as the information and policies that must be provided to the Documentation / Database Contractor(DDC), and the Review Contractor(RC).

- The State appreciates CMS' realization that the PERM "production cycle" will span more than a 12-month fiscal year period.

  However, CMS' estimate that the PERM production cycle will take approximately 23 months is new information that requires us to revise our estimate of the amount and duration of personnel and financial resources required for a successful completion of a PERM project. We expect CMS to seriously consider substantial revisions to the PERM project based on the experience of participating States.

III. Analysis and Response to Public Comments

- We respectfully request CMS reconsider the decision to include "Denied Claims" as a stratum for analysis in PERM.

  The technical and logistical problems the State would encounter in producing a list of "adjudicated denied claims" would add considerably to the State's burden to provide information to the SC. In addition, the necessity of tracking the rebillings of the denied claim would add to the burden of providing information to the DDC. Further, the difficulty in determining a sample size based on dollar value of the stratum would be most difficult considering the dollar value of a denied claim is zero. While the task of determining improper denials is a laudable one, the State thinks that including Denied Claims in the current PERM methodology is inappropriate. The State suggests CMS remove Denied Claims as a review stratum for FY 2007 PERM States, and constitute a focus workgroup, similar to that of the eligibility workgroup, with the task of determining a workable methodology for measuring error in Denied Claims to be implemented by FY 2008 PERM states.

- The State respectfully directs CMS to its stated desire to consider methods to minimize duplication of efforts, as the State will have already procured documentation from the provider.

The final interim rule notes that the DDC will request records for PERM regardless of whether overpayments have already been identified by other State review systems.

- The State appreciates the inclusion of a "difference-resolution" process for resolving instances where the State may not agree with the RC's findings of payment error.

  Included in the proposed "difference resolution" process is the provision that the State may appeal to CMS for final resolution if necessary. With the assumption that the number of unresolved differences between the State and the RC will be very small, this State suggests that unresolved differences be simply called "undetermined," and not be included in either accuracy or error rate calculations. This class of "undetermined" cases is allowed for eligibility reviews that cannot be accurately determined, and could also be allowed for medical review cases. A class of "undetermined" would prevent contentious relations between the State, RC, and CMS.

- We regret that CMS cannot exempt PERM-related expenses from the 10 percent SCHIP cap on administrative expenditures.

  The State is concerned that the additional administrative costs associated with the SCHIP eligibility reviews could exceed the State's 10 percent administrative cap. This may result in termination of medical insurance coverage for an undetermined number of SCHIP-eligible children.

- The interim final rule is silent on the issue of CMS monitoring or evaluating the success of the States' corrective action plans.

  We request that CMS provide a rationale for requiring a corrective action plan from the PERM States when no implementation assistance, monitoring, or program evaluation will be provided by CMS. It is assumed that States have an interest in and ability to develop, implement, and evaluate their own corrective action plans.

- The State requests CMS reconsider its decision regarding the establishment of an advisory committee.

  The decision not to have an advisory committee was based on the assumption that States had had ample opportunities to comment through the rulemaking process. The States appreciate the opportunities to comment on proposed regulations, and appreciate that CMS has incorporated many States' recommendations into the final rule. However, many of the methodologies and provisions proposed in this final rule have never been tested in either the PAM or PERM pilots, nor by any of the FY 2006 PERM participants. A PERM advisory group, with a substantial representation of States, would be a prudent, effective, and valuable resource to

CMS, Federal contractors, and the States. This advisory group need not be permanent, but it should be in place for at least through FY 2009, through the first complete cycle of PERM projects.

IV. Provisions of This Interim Final Regulation

- The state requests clarification regarding the managed care sample size.

  Section IV (B) states that the managed care sample size will be approximately 500 and will meet a 3 percent precision level. The State's preliminary calculations suggest a sample size about 4 times larger for a 3 percent precision level.

- The State encourages CMS to reconsider requiring the State agency responsible for the eligibility review to be independent of the State agency responsible for Medicaid and SCHIP policy and operations.

  Federal regulations allow the State agency responsible for Medicaid policy and operations to perform the MEQC reviews. It is unclear why CMS has concluded that there could be a conflict of interest with PERM reviews but not with MEQC reviews. MEQC reviews include the provision for FFP disallowance and PERM provides for the provision of overpayment recovery. Overpayments identified as part of PERM reviews will likely be born by the states, just as disallowances under MEQC are born by the states. CMS's position on this issue is not logical. Why address PERM differently than MEQC? Finally, requiring an independent state agency perform the PERM eligibility reviews will unnecessarily increase costs and provide no measurable benefit over having the reviews performed in-house.

- Requiring the State perform eligibility reviews within existing resources will have a significant financial impact on the State.

  Since States will be required to conduct the eligibility reviews without a Federal Contractor, we respectfully disagree with CMS' assertion that the burden and cost of these responsibilities will not significantly impact the States. CMS has estimated the total cost of eligibility reviews at approximately $18.1 million with the State's share estimated at $7.7 million. Citing CMS' estimates of 13,180 hours per program for PERM eligibility reviews, this would require the State hire or contract in excess of 20 personnel on an interim basis. Since the eligibility rules have not been finalized the State is unable to submit a credible request to the Legislature for funding.

- The State recommends CMS make the appropriate regulatory changes to allow PERM reviews to substitute for MEQC reviews in years when States are selected to participate in PERM.

CMS may not have authority to waive MEQC statutory requirements, but CMS does have authority to change the PERM methodology. Requiring States maintain two eligibility review systems results in a duplication of effort and overburdens the States with redundant processes and increased cost.

- The state recommends CMS allow Pilot MEQC States to convert to traditional MEQC status in PERM measurement years.

  Should CMS allow PERM reviews to substitute for MEQC reviews in years when States are selected to participate in PERM, CMS must ensure that Pilot MEQC States have the flexibility to perform traditional MEQC reviews and revert back to pilot MEQC reviews in non-PERM years. Guidelines for the transition must be developed.

- The State requests clarification regarding eligibility sampling process.

  On page 51062, 3rd column, CMS responded to several commenters' concerns that it is possible for PERM to be flawed by both dependent and independent variables. CMS responded by stating for FFS, the proposed method for accounting for both eligibility errors and medical and processing review errors is to draw two independent samples. For FFS, one sample will be drawn for eligibility review and one sample will be drawn for medical and processing reviews. For managed care the same would hold true.

  The above statement is inconsistent with section IV. The proposed regulation provides for two eligibility samples (active and denied) for Medicaid (FFS and Managed care combined). SCHIP samples would be drawn the same way as Medicaid. The CMS response above indicates that there would be a total of 8 independent samples (Medicaid and SCHIP) rather than 4. If this is correct the burden estimate for the eligibility reviews is inaccurate and should be doubled.

- The State requests clarification regarding reporting requirements.

  The reporting requirement for eligibility reviews is July 1 following the fiscal year under review. The State requests that CMS' confirm that there are no interim or periodic reporting requirements prior to the July 1 date.

In summary, we appreciate the opportunity to comment on the "Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement; Final Rule". The State of Washington is committed to its payment integrity program and continues to implement programs designed to assure accurate payments. We would welcome the opportunity to participate in further discussions with CMS and our fellow States about the PERM program methodology and design.

Sincerely,

Bob Covington, Director
Division of Systems and Monitoring
Health and Recovery Services Administration
Washington State Department of Social and Health Services

Cc: Doug Porter, Assistant Secretary, HRSA
Heidi Robbins Brown, Deputy Assistant Secretary, HRSA
Scott Kibler, Office of Payment Review and Audit, HRSA

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
1570 Grant Street
Denver, CO 80203-1818
(303) 866-2993
(303) 866-4411 Fax
(303) 866-3883 TTY

Bill Owens
Governor

Stephen C. Tool
Executive Director

September 26, 2006

Melissa Musotto
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS -6026-IFC2, Mail Stop C4-20-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Musotto:

Attached, please find the Colorado Department of Health Care Policy and Financing's response to the Payment Error Rate Measurement Supporting Statement Interim Final Rule issued on August 28, 2006. We appreciate the opportunity to comment.

If you have any questions, please do not hesitate to contact me at (303) 866-3676 or by e-mail at donna.kellow@state.co.us.

Sincerely,

Donna Kellow
Audit Coordinator

cc: Lisa Esgar

Comments to the Proposed Rule
Regarding the Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Program

Colorado Department of Health Care Policy and Financing
September 26, 2006

The Colorado Department of Health Care Policy and Financing (the Department) seeks clarification on several items within the interim final rule published by the Centers for Medicaid and Medicare Services (CMS) on August 28, 2006 as well as other supporting documents related to the Payment Error Rate Measurement Program.

Overall Questions

- The interim rule notes that Colorado being a "year two" state will be participating in PERM measurement for both Medicaid and SCHIP, as well as, conducting eligibility reviews for both Medicaid and SCHIP. In addition, the managed care portion will also be implemented. This had not been clear in previous interim drafts and rules, therefore, the late notice on this makes it nearly impossible for states' budgeting schedules and for the Department to receive funding in order to be prepared to implement this project. We respectfully ask that CMS consider deferring implementation until FFY 2008 and/or staggering programs.

- There is not a clear schedule or timeline for when samples of the eligibility component need to pulled and reviews to begin. Again, if this is implemented without sufficient time, it will put an unrealistic expectation on the states.

- It would be beneficial to states if CMS would provide an overall timeline for the PERM project so that states have a firm understanding of the schedule and expected deadlines.

- In the Federal Register, Volume 71, No. 170, September 1, 2006, page 52080, it notes that states will be able to contract out the PERM eligibility reviews due to resource concerns. However, if CMS does not allow the states sufficient time to implement the elgibility reviews, year two states will have difficulty utilizing this option since contracts must be secured through an open competitive process.

- The interim rule does not clearly define what all must be done as part of the corrective action plan. Please provide more information.

- The burden estimate that CMS proposes does not seem to fully encompass many aspects of the interim rule, especially since numerous sections of the rule remain unclear. The Department requests that CMS revisit the burden estimate once many of the other issues are resolved.

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Regarding page 51064

CMS notes that, "...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", please better define what is meant by this statement.

Regarding page 51067
42CFR 431 and 457, III. Analysis of and Responses to Public Comments D. Appeals

CMS notes that, "We have provided States with the opportunity to review the RC's error findings on all claims and have these errors reversed if the State can demonstrate the claims were correctly paid through the difference-resolution process. This is the vehicle we intend the States to use to participate in the reviews. For claims where error findings stand, the State must recover the overpayment from the provider under section 1903(d) or section 2105(e) of the Act. The RC will make available to the State the information on which the RC made its determination that a claim was improperly paid."

However it appears that states are only allowed to dispute the Review Contractor's error findings on claims with a difference of more than $100. From participation in pilot projects for both PAM and PERM, approximately 90% of the errors identified were for less than $100, yet states must recover the overpayment from the provider. The federal share of the overpayment would have to be paid back within 60 days from the date the overpayment was identified. The process of recovering these overpayments is not cost effective. If the provider appeals the decision, a significant amount of time and expense would be incurred to recover a small dollar amount. As it is fiscally imprudent to pursue such recoveries, the Department asks that CMS consider a minimal dollar amount and that overpayments of under $100 should be exempt from recovery and exempt from payback of the federal share.

Regarding page 51069
42CFR 431 and 457, III. Analysis of and Responses to Public Comments E. State Requirements 1. Collection of Information b. State Cost and Burden

CMS notes that, "States will be compensated at the SCHIP match rate, similar to other Federal audits. We are not considering exempting the costs of PERM-related activities from the 10%cap on SCHIP administrative expenditures".

This may cause Colorado to exceed their 10% administrative cap and put states in violation of the Social Security Act Title XXI.