State of California—Health and Human Services Agency
Department of Health Services

California
Department of
Health Services

SANDRA SHEWRY
Director

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Governor

OCT - 3 2006

September 26, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC2
Electronic Response: http://www.cms.hhs.gov/eRulemaking
PO Box 8013
Baltimore, MD 21244-8013

Response to Interim Final Rule 42 CFR Parts 431 and 457
Medicaid Program and Children's Health Insurance Program (SCHIP)
Payment Error Rate Measurement (PERM)

This communication provides the California Department of Health Services' (CDHS) Electronic response to the interim final rule published in the Federal Register on August 28, 2006 (Volume 71, Number 166) at pages 51050 to 51085.

Provisions of the Interim Final Rule

Page 51051, CMS Rulemaking

CMS:
The intended effects of the proposed rule were to have states measure improper payments based on fee-for-service, managed care and eligibility reviews; to identify errors to target corrective actions; to reduce the rate of improper payment; and to produce a corresponding increase in program savings at both the state and federal levels.

Comment:
California offers to submit the findings of its 2004 and 2005 Medi-Cal Payment Error Study (MPES) in lieu of conducting a PERM study of California in 2007. The MPES is the only study that goes beyond identifying the payment of claims correctly to include an estimate of fraud, waste and abuse. CDHS staff conducts onsite visits to medical

offices of prescribing and dispensing providers to ensure that all aspects of the services and claims were appropriate. The review method employed in the MPES exceeds the requirements of both the Payment Accuracy Measurement and PERM. California is beginning the MPES 2006 which is expected to be released in the spring of 2007.

Page 51053, Use of Federal Contractors

CMS:
"For FY 2006, we have engaged three contractors: A statistical contractor (SC); a documentation/database contractor (DDC); and a review contractor (RC)."

Comment:
Contracting with three separate contractors to perform separate review responsibilities places a difficult burden upon states. It will be necessary to divert staff from their normal duties to respond to requests for information and assistance from three separate independent contractors in conducting their respective parts of the PERM. This will create a duplication of work that will be placed upon the states. This new workload for states comes upon increased unfunded workload required by CMS due to increased numbers of new federal auditors and new unfunded federal mandates. Budget cuts have caused state agencies to reduce staffing to minimum levels.

Page 51055, Payment Error Rates

CMS:
"Only those states selected for review each year will incur costs, by providing information necessary for claims sample selections and reviews, providing technical assistance, as needed, and developing a corrective action plan to reduce the error rate. The states will be reimbursed for these activities at the applicable administrative Federal match under Medicaid and SCHIP."

Comment:
CMS should provide 100 percent reimbursement to states for staff time and other related expenses incurred assisting in the PERM review instead of the current federal matching formula. The PERM will require that state staff be re-directed from their normal anti-fraud duties to provide information and technical assistance to the three federal contractors. The costs incurred by the states will exceed the current reimbursement by CMS. It would be helpful if CMS would provide its estimate of the time states will be required to spend on PERM related activities based on previous

experience with other states who have completed their respective PERM reviews in 2006.

Page 51058, B. Methodology, Denied Claims

CMS:
The IPIA defines an improper payment as ".....any payment that should not have been made or that was paid in an incorrect amount including overpayments and underpayments." OMB guidance M-03-13, published May 21, 2003, states that incorrect amounts are overpayments and underpayments including inappropriate denials of payment of services."

Comment:
As previously noted in CDHS' comments to the October 2005 IFR, a denied claim does not result in any type of payment, either overpayment or underpayment, of federal funds to providers. Claims are denied based upon established guidelines for just reason(s) or cause(s).

California CDHS again requests a response as to whether a denied Treatment Authorization Request (TAR) would be considered a denied claim.

Page 51063, Expanded FY 2007 Error Rate Measurements: Eligibility

Comment:
The eligibility review methodology that will be utilized in the 2007 PERM study is at odds with the eligibility methodology that will be used to conduct the MPES 2006. Unless either party revises its process for reviewing eligibility, California will be out of compliance with the PERM study.

Page 51076, Section 431.998: Difference Resolution Process

Comment:
CMS has designed the difference resolution process as the means by which states may formally disagree with the findings of the federal contractor. States will be required to notify the contractor in writing of their disagreement with claims identified as being in error. The states will be required to have a factual basis for filing the disagreement for any claim and present valid evidence to support that the claims were paid correctly. If the contractor agrees that the claim(s) was/were in fact paid correctly, it will adjust the state's error rate.

This process in effect, places the federal contractor in the position of being sole party to determine claim errors and in deciding if it has not correctly identified a claim to be in error. California recommends that CMS implement an appeal process that would allow a neutral party to review and adjudicate appeals. This would provide states some assurance an impartial process is in place by which disputed claim errors can be discussed and resolved. To have a process in place where a contractor can make decisions that affect state funding is an inappropriate delegation of responsibility by CMS and deprives states of required due process.

Page 51078, Section 431.970(b): Information Submission Requirements

CMS:
Section 431.970 (b) requires providers to submit medical record information to the Secretary for estimating improper payments in Medicaid and SCHIP. We believe this action would not have a significant cost impact on providers. We continue to estimate this burden to be a part of a provider's usual and customary business practice.

Comment:
California is concerned that providers will be required to re-direct staff to tasks related to photocopying medical records for submission for review purposes. In small offices where staffing is reduced, this requirement will create an administrative burden for providers. There will be expense incurred in having staff retrieving and photocopying medical records. This will be significant additional expense for many providers.

Page 51084, Section 431.1002 Recoveries

CMS:
As previously stated, recoveries of federal funds are governed under current law and regulation. This interim final rule with comment does not seek to make revisions, so we are not accepting these recommendations.

Comment:
The possibility of recoveries may place a tremendous strain on state budgets. The purpose of the PERM should be to provide assistance and guidance to the states in how to deter/avoid claim errors. The requirement for federal recoveries places a somewhat punitive action against states when the process should be one in which CMS is partnering with states and providing technical assistance in identifying and reducing claim errors and preventing inappropriate payments from being made.

If you have any questions please contact David Botelho, Deputy Director, Audits and Investigations at (916) 440-7550.

Sincerely,

David Botelho
Deputy Director
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12

SEP 27 2006

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September 25, 2006

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

RE: CMS-6026-IFC2
PERM Final Rule

To Whom It May Concern:

The Commonwealth of Virginia is pleased to provide these comments in response to the publication of the "Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement; Final Rule", which appeared in the August 28, 2006 edition of the *Federal Register*. We appreciate the effort made to resolve many of the issues surrounding the eligibility review portion of the PERM requirements, particularly the movement to a recipient based sample from a claims based sample. We find, however, that we need further clarification on several points. The following comments summarize our key concerns.

- §431.974(2) describes the supervision and placement of the PERM unit to perform eligibility reviews. The regulations specify that "the agency and personnel responsible for the development, direction, implementation, and evaluation of the eligibility reviews and associated activities, including calculation of the error rates under this section, must be physically and functionally separate from the State agencies and personnel that are responsible for Medicaid and SCHIP policy and operations, including eligibility determinations." (*71 FR 51083*)

  This regulation is unclear. For example, in Virginia, the Department of Medical Assistance Services (DMAS) is responsible for Medicaid and SCHIP policy and implementation. DMAS contracts with the Department of Social

Services to conduct eligibility reviews and Medicaid Eligibility Quality Control (MEQC) reviews. Virginia requests a clarification of the rules to determine which unit/agency can perform the PERM eligibility reviews. Who is prohibited from performing the PERM reviews? Is it CMS' proposal that we contract the service or hire staff dedicated to PERM?

In addition, this section seems to contradict a response to a comment regarding the difficulty of staffing for PERM every three years. The comment addresses use of eligibility reviewers on an interim basis between PERM selection years to enhance MEQC or SCHIP program integrity activities *(71 FR 51068)*, which suggests we continue staffing current operations in the agency.

- Several responses to comments regarding the interim final rule indicate that there continues to be consideration given to methods for reducing duplication of effort between PERM and MEQC eligibility review procedures. We understand that there are two competing regulations that address these reviews. However, states need a final decision in order to plan for adequate staffing.
  1. Will CMS allow MEQC staff to perform the PERM review to satisfy the requirement for the MEQC program?
  2. Could the PERM review substitute as a MEQC pilot program, which would preclude financial penalties that can apply to the standard MEQC program?
  3. IF QC is allowed to conduct PERM reviews as a substitute for MEQC requirements, can MEQC staff conduct SCHIP eligibility reviews in lieu of MEQC requirements or will states with SCHIP programs that are not Medicaid expansion programs be required to hire separate staff for the SCHIP reviews?

- §431.978(d)(1)(i) addresses the universe for sample selection of eligibility reviews. It specifically excludes cases in which the Social Security Administration, under a 1634 agreement, determines eligibility for Supplemental Security Income recipients. Virginia is a 209-B state. What will be the methodology used when determining Medicaid eligibility for SSI recipients in 209-B states? *(71 FR 51083)*

- §431.978(d)(2) describes the negative case universe for sample selection of eligibility reviews. The PERM regulations specify to exclude cases denied or terminated based upon incomplete applications or cases where beneficiaries

did not complete the redetermination process. Virginia would like this procedure clarified with examples. *(71 FR 51083)*

- We are concerned that the eligibility reviews will significantly impact the SCHIP program's 10% cap on administrative expenditures. We believe this should be separate and apart as it was not part of the consideration when the cap was created. §431.980 describes the eligibility review procedures; SCHIP active case reviews are specifically addressed in §431.980(d)(2). There is an additional step in the SCHIP reviews to determine if the eligible recipient should be enrolled in Medicaid rather than SCHIP. Under the *Regulatory Impact Statement*, estimates for eligibility reviews per program are approximately $400,000 (*71 FR 51080*). There are some additional expenses related to pulling samples and preparing corrective action plans for each program. References to the SCHIP program in the *Analysis of and Response to Public Comments* state that there will be no consideration of exempting the PERM activities from this cap (*71 FR 51069*).

Thank you for considering our comments. The Commonwealth of Virginia is committed to implementation of 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,

Patrick W. Finnerty

PWF:sal

C: Louis Elie
Sharon Long

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF
MEDICAID & MEDICAL ASSISTANCE

SEP 27 2006

TELEPHONE: (302) 255-9500

September 26, 2006

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

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

Dear Sir/Madam:

This letter is in response to the Federal Register/Vol. 71, No. 166 dated Monday, August 28, 2006/Rules and Regulations. Please respectfully accept our comments on behalf of Delaware Health and Social Services/Division of Medicaid & Medical Assistance. If you have any questions or concerns regarding the response please contact Susan M. Mateja at (302) 255-9607.

I. Background

" For those programs with significant erroneous payments, Federal agencies must provide the estimated amount of improper payments and report on what actions the agency is taking to reduce them, including setting targets for future erroneous payment levels and a timeline by which the targets will be reached."

Delaware participated in the Payment Accuracy Measurement (PAM) Pilot Project and the Payment Error Rate Measurement (PERM) Pilot Project. We were also selected to for the PERM Project in 2006. During each year of the projects the implementation is extremely burdensome to states. The Improper Payments Information Act of 2002 (IPIA) requires that the heads of Federal agencies annually review programs they oversee that are susceptible to significant erroneous payments, not State agencies.

B. CMS Rulemaking

"Our revised approach adopted the recommendation to engage Federal contractors to review State Medicaid and SCHIP FFS and managed care payments."

During the PERM Project in 2006 CMS hired 3 contractors to perform the PERM audit. There is a significant amount of state staff time necessary to coordinate information

between all 3 contractors and Electronic Data Systems (EDS) Delaware's fiscal agent. We recognize that there is a learning curve for the new contractors. Delaware was informed that they were selected in mid November of 2005. To date one of the contractors charged with collecting the medical records providers has not even sent out the first request. We have done a significant amount of provider education about the PERM project, however, the delay in collecting the documentation from providers does not allow much time for the state to respond to any findings or perceived errors. We do not believe that the process of hiring 3 contractors is effective in measuring error rates.

"States will calculate the State-specific eligibility error rates."

During the pilot projects eligibility was a component of the review but only 100-200 records were audited. As proposed in the regulation approximately 504 eligible records annually and 200 negative cases will be audited for accuracy. Based on our experience in the pilot projects the amount of records will cause an extreme burden on states. During the Medicaid Eligibility Conference held in Denver, Colorado from September 19-21, 2006 a presentation stated ***"Each month the State determines the universe for the previous sample month, excludes allowed cases, and stratifies the sample."*** *During the Pilot Projects the eligibility sample was drawn from the adjudicated paid claim sample. The process described above truly duplicates the MEQC efforts and process that is already in place. Delaware recommends that states be allowed the option of substituting PERM for MEQC without the disallowance.*

"Our State selection will ensure that a State will be measured once, and only once, every 3 years in each program."

*Selecting states on a rotating basis will allow states to budget and plan for the PERM Project fiscal and workload impact, however, we believe that Federal funding should be available to states to implement the project. Additionally, a presentation was given at the Medicaid Eligibility Conference held in Denver, Colorado from September 19-21, 2006 where it highlighted "****Who reviews: the agency that develops, directs and implements the reviews must be functionally and physically separate from the State agency responsible for Medicaid and SCHIP policy and operations, including eligibility determinations."*** *We believe that this is forcing States to hire an expensive outside consultant to conduct the eligibility reviews that are not familiar with the States policy regarding eligibility. Hiring an outside contractor will still be a burden to states as the collection of documentation to prove eligibility and the coordination efforts to manage the outside consultant will still be necessary. Delaware recommends that states be allowed to substitute PERM for MEQC without disallowance.*

"The October 5, 2005 interim final rule invited further comments on methods for estimating eligibility and managed care improper payments. We received very few comments regarding managed care and a number of comments regarding eligibility."

We responded to the interim final rule that was published on October 5, 2005. The eligibility portion of the rule was not addressed. We also responded to the eligibility

methodology that was published in May of 2006. Please refer to our previous comments for this section.

"(f) Repricing information for claims that are determined to have been improperly paid;"

We do not recall repricing information as part of the pilot projects. Can you please provide further guidance on the statement?

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

Please provide additional examples for clarification on a claim that changed in substance after selection.

"(j) Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining error rates in Medicaid and SCHIP."

This is an open statement that implies that states provide anything that is requested without clear guidelines or direction.

C. IPIA Implementation

"We also announced in the October 5, 2005 interim final rule our intentions to establish an eligibility workgroup to make recommendations on the best approach for reviewing Medicaid and SCHIP eligibility within the confines of current statute, with minimal impact on States and additional discretionary funding. We convened an eligibility workgroup comprised of DHHS (including CMS and, in an advisory capacity, the Office of the Inspector General (OIG), OMB, and representatives from two States."

In our multiple responses to the interim final rule we offered to be involved in the development of the eligibility methodology for the PERM Project. There were many states that participated in the Pilot Projects that were not part of the eligibility workgroup. How were the 2 states selected to be a part of the eligibility workgroup? Did the 2 states participate in the Pilot Projects? Can you please provide a schedule and minutes from the meetings that were held in developing the eligibility review methodology?

II. Provision of the October 5, 2005 Interim Final Regulations

A. Selecting States for Review

"We will use a rotational approach to review the States in Medicaid. For each fiscal year we expect to measure 17 States. The result is that each State will be measured once, and only once, every 3 years. The rotation allows States to plan for the reviews because States know in advance in which year they will be measured."

If states choose to hire staff to implement the PERM Project in the Year that they are selected, what will the staff do during the 2 years off? If states choose to hire a consultant to perform the reviews there is still a significant amount of coordination to provide documentation to determine eligibility and to manage the consultant. This will ultimately be costly and burdensome on States.

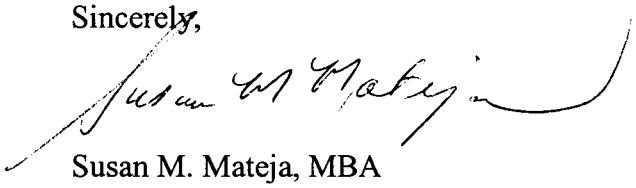
B. Use of Federal Contractors

Statistical Contractor

"We will expect that the average sample size will be 1000 FFS claims and 500 managed care claims per State program in order to achieve a 3 percent precision level at the 95 percent confidence level (based on the range estimated during the PAM/PERM pilots)."

This sampling methodology is different then the information provided at the Medicaid eligibility conference. In all of the correspondence released by CMS the sampling size and methodology varies and is extremely confusing for states to determine exactly what will be expected from them. Please clarify exactly what the PERM Project sampling size and methodology for each area of the project.

Sincerely,



Susan M. Mateja, MBA
Policy and Planning Administrator
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SEP 26 2006 14

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September 27, 2006

Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-8013

Attention: CMS-6026-IFC2

Dear Sir/Madam:

We welcome the opportunity to comment on the proposed final rule as published in the August 28, 2006 Federal Register, Volume 71, No. 166, page 51050. The State of Idaho, Department of Health and Welfare, respectfully submits comments on the Final Rule regarding Payment Error Rate Measurement (CMS-6026-IFC2).

The State of Idaho is committed to implementing and maintaining programs, policies and processes to ensure payment integrity. However, as outlined in the attached comments, the State is concerned that sufficient consideration has not been given to the detail of the regulation. We appreciate that CMS has acknowledged the burden that the proposed rule places upon the States. Sampling States every three years should reduce the burden, but we continue to be concerned about the effort that States will need to devote to assist the Federal contractors in order for the State to have confidence in the contractor's findings.

Thank you for your consideration of our comments.

Sincerely,

LESLIE M. CLEMENT
Administrator

LMC/pc/bsr

Idaho Comments to the Final Rule
Medicaid Program and State Children's Health Insurance Program
Payment Error Rate Measurement
Federal Register on August 28, 2006
CMS-6026-IFC2

1. It is appreciated that CMS has listened to States' concerns regarding the State administrative cost and burden to comply with the proposed rule. However, we continue to believe that CMS has seriously understated the amount of State resources needed. We also continue to believe that since IPIA is a Federal obligation, the State's participation in this project should be fully funded by CMS. In the interim final rule, CMS has included an estimate for the cost of providing information to review FFS and managed care claims, conducting eligibility reviews and developing a corrective action plan. However, there are no estimated costs included for:

   - Working with the Federal contractors to provide assistance and training in the nuances of each State program, policy, policy applications and the claims processing system that are unique to that State.
   - Resolving differences in the findings. We understand that filing a difference resolution request is optional to States; however, it would not be prudent for States to not file requests when it is clear that the contractor's findings are incorrect. Monitoring the disposition error report and filing a difference resolution request will be a manual process.
   - Providing information on claims that were selected but were changed after selection, (i.e. provider appeals, adjustments, etc.). A process, either electronic or manual, will have to be developed and maintained in order to monitor for changes after selection.
   - Monitoring and maintenance of corrective action plans. CMS requires a corrective action plan be written and maintained. If the plan is found to be inadequate, then addendums/corrections will need to be sent to CMS for review and acceptance.
   - Providing the same information to multiple Federal contractors. While the contractual agreements have been written to assure that the contractors share information and communicate with each other, we have found that this is not occurring. Contractors do not appear to be communicating or coordinating information amongst themselves and each other so States are asked to provide the same information multiple times.
   - Providing other information that the Secretary determines is necessary for estimating improper payments and determining error rates in Medicaid and SCHIP. The requirement is too vague to determine impacts and costs to States.
   - Follow-up activities associated with obtaining information from providers who have failed to submit requested medical records. This follow-up by States is critical since failure to provide documentation or submission of insufficient documentation results in an error to the State.

- Providing provider contact information that has been 'verified by the State as current'. We rely on providers to notify us on an as needed basis when their contact information has changed. Requiring States to verify contact information will require contacting every provider or subset of providers, both active and inactive, to verify provider address and phone numbers.

2. What assurance do States have that comparisons among states are not being made when reporting the error rates? Because of the wide variation in States' Medicaid and SCHIP programs, this assurance in needed to order to reassure States that unwarranted comparisons are not being made.

3. Enrollment in Idaho SCHIP program only represents approximately 10% of the total of Medicaid and SCHIP participants. The annual sample size of 1000 claims per State per program has been estimated. Since Idaho's SCHIP program is only 10% of the total population, it would appear that the SCHIP program is being proportionately over sampled.

4. The cost of conducting the SCHIP reviews will become a SCHIP administrative expense. SCHIP administrative costs are capped at 10% of benefits provided. States already maximizing use of their administrative dollars could end up having to drop to state-only dollars which could constitute an unfunded mandate. Additionally, states like Idaho that have implemented child health services initiatives will have the costs of the PERM reviews competing for the same dollars that fund programs. This means that this rule-making has the potential to cause Idaho's children to lose services currently funded by SCHIP.

5. The formal procedures for resolving differences have not been published. States should be given the opportunity to review and comment on these procedures prior to implementing the procedures to ensure that the States' concerns as expressed in the previous public comments have been addressed.

6. Error rates resulting in recoupments at the universal level should not be applied to the total expenditure of the States' Medicaid budgets. Only claims which are identified as paid in error should be recouped. To do otherwise would have a significant impact to States' budgets and provider relationships.

7. While including claims under active provider fraud investigation may not compromise the investigation, it may skew the error rates and appears to be a duplication of effort since medical reviews are oftentimes a part of the fraud investigation.

8. States who are preparing for or are in the process of implementing a new MMIS or eligibility system should be excused from selection until the implementation project(s) is completed and passed by CMS. Resources such as time, money and technical support are already stretched to a maximum during these types of projects.

9. The rule requires 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. This will be particularly difficult in Idaho since the Idaho Department of Health and Welfare (DHW) is the umbrella 'agency' from these programs. It would appear that an 'agency' external to DHW will need to be trained on how to do eligibility determinations that would enable them to conduct reviews accurately. This would be an additional administrative cost and burden to the State.