Submitter : Dr. Q. Michael Ditmore **Date:** 11/04/2005

Organization : Missouri Division of Medical Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-6026-IFC-13-Attach-1.DOC

MISSOURI DIVISION OF MEDICAL SERVICES PRO GRAM INTEGRITY UNIT
COMMENTS/CONCERNS REGARDING DRAFT PERM REGULATIONS
October 5, 2005

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

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

MISSOURI DIVISION OF MEDICAL SERVICES PRO GRAM INTEGRITY UNIT
COMMENTS/CONCERNS REGARDING DRAFT PERM REGULATIONS
October 5, 2005

Page #	Section	CMS Wording	Missouri DMS Comments/Concerns
58264 58266	Claims Universe and Sampling (Sampling Issues)	In FY2007, we will estimate separate error rates for FFS and managed care. We will also produce a combined FFS and managed care error rate for each State for each program in addition to providing a national error rate for each program.	Missouri agrees with the comments that the capitated and Fee-For-Service (FFS) error rates are not comparable. The majority of the managed care sample has less processing requirements and errors. This can be present a difference in the error rate image between FFS and programs. We believe CMS, or its designee, for the final reports should include an explanation addressing this difference.
58267	Overpayment and Underpayment Errors	In order to be in compliance with IPIA, we must follow OMB guidelines regarding total gross overpayments and underpayments to derive error rate estimates. However, we also intend to report separately the amount of overpayment and underpayments.	Missouri commends CMS's intention to also report the amount of overpayment and underpayment separately.
58268	Review Procedures Medical Reviews	Entire comments and responses in Section D1. CMS responses to nearly all medical review concerns are States are no longer performing the medical reviews, and will not incur the cost of the reviews.	During the PERM pilot, Missouri's medical record reviewers pursued additional documentation in about 70% of records requested. Though our initial request gave an itemized list of records requested to indicate doctor's orders, daily progress notes, etc. were needed. We frequently received only summaries. Obtaining complete documentation required more than 5-to-6 provider contacts and several different persons being notified of items missing. Inadequate documentation may be a frequently cited error by the contractor(s) because the contractor has no incentive to relentlessly request missing information. As an example, verifying each hospital stay was necessary meant contact with the medical records department who refers you to the copy service that states those records were sent. Therefore, you go back to the medical records department and have difficulty speaking to the same employee twice. You also may find the record is stored elsewhere, has been archived, or that outpatient and inpatient records are in separate areas, etc. Obtaining complete medical records is a time-consuming process. The state will repay the federal portion if the contractor is not as responsible as the state would be. We have little confidence the contractor will be as successful as the State in getting that last piece of information that proves medical necessity.

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

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

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

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

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

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

Submitter : Mrs. Evette Patton **Date:** 11/04/2005

Organization : OIG/Kentucky Department for Medicaid Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

Please see Word attachment

CMS-6026-IFC-14-Attach-1.DOC

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF THE UNDERSECRETARY FOR HEALTH

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Governor

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James W. Holsinger, Jr.,
Secretary

November 4, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
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Department of Health and Human Services
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Attention: CMS-6026-IFC

Re: Kentucky
Comments on October 5, 2005 Federal Register Notice
File Code: CMS – 6026 – IFC

The following highlight the Commonwealth of Kentucky's comments and concerns with the recently published notice in the above mentioned Federal Register:

Provisions of the Proposed Rule (II)

- Regarding how to best determine an error rate for managed care in Medicaid and SCHIP, the guidance and instructions from CMS for the PERM pilot managed care reviews serve as a thorough and appropriate methodology.

Analysis and Response to Public Comments on the Proposed Rule (III)

- The publication notes that, "accepting State samples with larger standard errors may produce a national error rate that was compliant with OMB guidance." By allowing larger standard errors for each State's sample, each State would have a much smaller sample size and still achieve the requirement issued by the IPIA, which is to report a national error rate. The publication addresses the concern that by accepting smaller sample sizes for each State, that States would have insufficient information to

identify vulnerabilities and to implement corrective actions. However, we disagree with this rationale, as States are already performing activities to eliminate reimbursement weaknesses through SURS, PRO, and payment integrity program activities. Also, each State's sample size would remain large enough to formulate corrective action documents. Since a Federal contractor will be performing the work, it would be efficient for the data to be combined from the start with the end goal be producing a national error rate.

- The timelines associated with the States submitting the quarterly data are unclear. If selected to participate in the study, when would the data from 10/1/05 through 12/31/05 be due from the State to the Federal contractor and each quarter thereafter? If the error rate is to be reported to OMB by November 15th of each year, as stated in Section I. Background, there may not be sufficient time for the Federal contractor to receive the data for the last quarter of FFY 2006 (*i.e.*, 7/1/06 through 9/30/06) and then request medical documentation, review the claims for processing errors, and report on the findings.

- Regarding the review of denied claims, while we recognize the importance of reviewing these potential underpayments, the costs of compiling this data was not included in the PAM cost study. (The first time denials were considered was during the PERM pilot.) Experience from the PERM pilot has shown that the population of denied claims is large (Kentucky Medicaid had over 2 million denials in the fourth quarter of 2004). Providing this universe data to the Federal contractor will be time-consuming and the costs of this activity may not have been properly estimated.

- The estimated State burden for submitting quarterly claims data is 200 FTE hours per quarter. We question whether this time estimate is adequate given that Fiscal Intermediaries must write new ad-hocs or queries for each stratum and the data must be reviewed for quality. Due to the unique design of the data extracts significant burdens may be placed on States if the Federal contractor must request multiple data extracts because of incorrect data queries provided by the Fiscal Intermediaries.

- It is mentioned that CMS will direct the national contractor on stratification issues. However, States will also need to know these directions in a timely fashion so they can properly submit its data in the required stratified format.

- With regard to claim adjustments, the publication is not allowing for adjustments to claims outside a 60-day window. Yet, some State processing functions are set up to reconcile after 90 days. If an adjustment correctly occurs within the 90-day timeframe, the sampled claim would unfairly be considered an error and would not be recoupable because of the adjustment. (States can only recoup non-adjusted claims as of the date of recoupment.)

- Regarding the comment and response to TPL not being reported on the line-item level, it will be necessary to review all line items of a claim (not just the sampled detail line) when TPL or Patient Liability is involved. This can be accomplished by using the data extracts submitted by the States.

- It remains unclear how the date of erroneous payment identification is defined for the purposes of returning the Federal share within 60 days. Possible options include the date of re-pricing by the State and the date of the final report. States need the opportunity to review any errors before a decision is made to recoup.

- It appears that the Federal contractor will not coordinate with States to ensure that medical record request letters are not sent to providers under active investigations. We suggest that this be reconsidered because if these providers were to be included, the response rate would decrease and would also cause roadblocks in ongoing investigations. This apparent lack of cooperation between the Federal contractor and the State may result in fewer recoveries from fraudulent practices as it may hinder the investigation. Note that the recoveries from fraud investigations are typically larger than recoveries resulting from a single claim's overpayment in a PERM review.

Provisions of the Interim Final Rule (IV)

- Since the Federal contractor will be working with each State's data, it must realize that States' data systems are different (field names can have different meanings and interpretations among States). Will the States need to reformat their claims data using standard headings prior to submission? Also, data differences between line item level and header level will need to be considered. For example, some fields are only reported on the header level and appear as null or 0 on a claim that is not the first line item. If not considered, these differences can result in invalid sampling plans as well as incorrect error or accuracy interpretations.

- Will the Federal contractor have access to each participating State's MMIS or will this be addressed in a separate document? The Federal contractor will need to use it to review contextual claims and other information (*i.e.,* prior authorization files, TPL databases, eligibility information) for both the processing and medical reviews. If provisions are not made in the rule that States must provide the contactor with their MMIS, the methodology of the Federal contractor performing the processing and medical reviews will be fundamentally flawed and would add substantial burden on the States.

- The publication lacks detail in how the States should submit the quarterly stratified data. (*i.e.*, specific computer format and if it should be submitted on DVD or through electronic transmission lines). These decisions can affect the costs associated with the project and the time it takes for the Federal contractor to receive and begin working with the data.

- It is mentioned that States will be responsible for re-pricing the errors identified by the Federal contractor. Would this be the opportunity for each State to review the Federal contractor's work and for States to dispute a potential error and provide more information? Due to the complexity of each State's Medicaid program, this review by the States prior to considering the Federal contractor's work as final is a crucial component of obtaining a valid national error rate that States can agree with and support.

- The publication mentions that States will provide the Federal contractor with claims that were included in the sample, but the adjudication decision changed due to the provider appealing the determination and the State overturning the original decision. This description is unclear and more clarification is required in order for States to correctly submit the requested information: it seems to refer to sampled denials that the provider appealed, but in that case an entire new claim is created (not an adjustment to a prior claim). By regulation, providers must accept the payment that Medicaid sends them. Providers can only appeal notices of overpayment (upcoming recoupments).

- The third column on page 58273 references Sections 437.978 and 437.982 of the proposed rule. Is this a typographical error where Sections 431.978 and 431.982 are supposed to be referenced? The proposed rule does not include any reference to Part 437, only Parts 431 and 457.

Collection of Information Requirements (V)

- CMS seeks comment on the accuracy if its estimate of the information collection burden and notes that the estimated burden for the State is 1,630 hours per State per program. From page 58266, 800 of these hours are estimated for the sole purpose of submitting the quarterly stratified claims data (200 FTE hours per quarter * 4 quarters). The remaining 830 budgeted hours left for each State's program to perform the other functions seems inadequate. Furthermore, there is a great cost burden associated with this staff time. We ask that CMS 100% federally fund these costs.

Regulatory Impact Statement (VII)

- We are concerned that CMS is underestimating the time and cost required to obtain medical records. Demonstration experience has shown that multiple provider letters and follow up phone calls are often required to ensure the collection of all necessary information for the medical reviewer to properly adjudicate the claim. This may include coordinating with States to mail claim recoupment letters if providers do not comply with the original request letter from the Federal contractor.

In closing, we appreciate that CMS listened to our concerns in the last round of comments to the previously filed proposal. However, we request that states be allowed the privilege of participating in the development of a workable solution to CMS's dilemma in meeting the requirements of the Improper Payments Information Act.

Thank you for considering Kentucky's comments. If you have any questions, please contact Zach Ramsey at 502-564-5472 or Evette Patton at 502-564-1012.

Sincerely,

Shannon R. Turner, J.D.
Commissioner

ZR/ep

Submitter : **Ms. Viki Brant** **Date: 11/04/2005**

Organization : **Alabama Department of Public Health**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC-15-Attach-1.DOC

October 27, 2005

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: William N. Parham, III
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: PROVISIONS of the INTERIM 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 interim regulations published by CMS in the October 5, 2005 edition of the *Federal Register*.

The State of Washington is committed to implementing and maintaining programs, policies and processes designed to ensure payment integrity within its health programs. However, as outlined below, the State is concerned that adequate consideration has not been given to the detail of this proposed regulation and the feasibility of implementation as currently described. Attached is a detailed response to the proposed interim rule, but the following summarizes our key concerns:

- CMS should abandon the proposed state-level error rate in favor of a national error rate.

  We question the CMS's rational 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 previous PAM/PERM pilots have clearly demonstrated a negative return on investment.

  Because of our strong commitment to payment integrity, Washington was among the first states to voluntarily participate in the Payment Accuracy Measurement pilot. However, the negative return on investment convinced us to terminate our pilot participation (see Table). The primary reason for this difference: Payment Integrity staff use sophisticated algorithms and models to identify targeted leads for investigation and audit. PAM/PERM results are based upon calculation of the number of claims that had any type of error at all (e.g. wrong code used) that have very minimal cost impact.

Payment Integrity ROI	PAM/PERM ROI
Washington returns **$7 for every $1** invested in overpayment, fraud and abuse detection efforts.	For three years standing, Washington returns **.10-.12 cents for every $1** spent.

Given the poor return on investment demonstrated under previous federal pilot programs, we recommend CMS abandon a state-level error rate in favor of national error rate. Additionally recommend that CMS further support expansion of state payment integrity programs that have demonstrated a positive return on investment.

- Implementation of a state-level error rate should be 100% federally funded.

  In the previously proposed PERM regulation, CMS justified the use of the states' workforce because they are the only ones with the expertise to determine if a Medicaid or SCHIP claim has been paid properly. The currently proposed interim rule reduces the cost burden to the State by engaging a federal contractor, but it is clear that significant state resources will still be required due the state unique expertise required to complete such reviews. Additionally, there is insufficient detail to accurately estimate the resources required to support the proposed regulation. Therefore we suggest that if CMS wishes to proceed with the current PERM regulation, it should utilize the expertise and of the State Medicaid agency to assist the federal contractor, and fund the additional state resources with 100% federal dollars.

- There is insufficient detail contained in the proposed regulations and the CMS Notice of Proposed Information Collection, making it is impossible for states to determine the full and complete impact that this initiative will have on state resources or adequately respond to the proposed rule..

  1) The level of interaction and support between the state and contractor should be further defined, particularly in error determinations and in resolving discrepancies between the parties.

  2) No provision is made regarding eligibility, and its role in determining or calculating payment error rates. Instead, the eligibility issue is deferred to the actions of a work group to be constituted at a later time.

  3) There is no provision for due process for the State. The State should have an opportunity to review the contractor's findings and confirm the accurate application of the State's policy. A dispute resolution process should be available should the State disagree with the contractor's determination.

  These are substantive issues that materially impact states and should be addressed before finalization of the proposed regulations.

- The proposed interim rule should not be focused on collection of overpayments, but should focus on calculation of an error rate and identification of opportunities to reduce the error rate.

  States already perform payment integrity activities which include established processes for identification, collection, and administrative remedies available for providers that dispute the identified overpayment. The proposed interim rule should not result in any change to these practices which establish necessary due-process.

  In the event CMS pursues alternative payment recovery from States, States should be provided an opportunity to review, comment, and if necessary appeal CMS findings in accordance with existing federal regulation.

  Additionally, identified overpayments should not be subject to the "60 day rule", 42 CFR, 433.316 until such time that the State agrees that an overpayment has occurred or administrative remedies available to the State have been exhausted.

- Initial claims included in the Federal contractor sample should be excluded if they are also under review by the Medicaid Fraud Control Unit, 42 CFR, 1007.11

In summary, we appreciate CMS departure in the approach to estimating improper payments by engaging a Federal contractor rather than requiring the State produce an error rate, but as indicated above we do not believe the interim final rule adequately addresses the State's concerns on process and protocol for measuring improper payments. 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,

Doug Porter, Assistant Secretary
Health and Recovery Services Administration
Washington State Department of Social and Health Services

Washington Comments on Interim Final Rule

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

File code: CMS-6026-IFC

Section	Topic	Comments
I	**BACKGROUND**	This section cites States participation in the PAM and PERM pilot studies in developing a methodology that can be used to generate a national level error rate estimate. It also cites the Improper Payments Information Act of 2002 and the requirement of the Secretary to produce estimates of the national error rate in Medicaid and SCHIP payments. The PAM and PERM pilot projects were not conducted under the aegis of the IPIA, and though the methodology of producing state-specific error rates is useful in developing a national error rate estimate, the IPIA does not suggest or require a state-specific error rate.
IV	**PROVISIONS of the INTERIM FINAL RULE**	
	National Contracting Strategy Requirements for Selected States	The decision to use a Federal contractor to estimate medical and data processing error rates reduces the cost burden to states. However, the states will allocate significant administrative resources towards the collection of information necessary to establish a state-level error rate. These tasks and responsibilities should be fully reimbursed with federal funds rather than at the administrative federal match rate. In addition, the national contractor methodology was not been tested in PAM and PERM studies. In the PAM and PERM methodologies, States took advantage of long and detailed knowledge of their own policies and practices in order to make error rate estimates. This knowledge is not easily transferred to a Federal contractor, or any other outside party. It is this knowledge transfer and implementation that has not been designed or tested, but is germane to generating an accurate error rate estimate.

Section	Topic	Comments
		States chosen to participate in the PERM project are required to provide "claim data" and expenditures. It is unclear what "claim data" encompasses. The resources needed by the States to meet this requirement would vary considerably depending on the level of detail required for "claim data." **Recommendation: Clarify the level of detail needed for "claim data" at this stage of the project.** States are required to submit quarterly adjudicated and stratified claims data. Since this occurs before samples are generated, it would be helpful to clarify the level of detail required at this stage. The resources needed by the States to meet this requirement vary considerably depending on the level of detail required for these data. **Recommendation: Clarify the level of detail needed for adjudicated and stratified claims data at this stage of the project. Also, clarify the handling of sample claims that are also under review by the State's MFCU.** States are required to provide verified and updated provider contact information. We assume this would apply only to those cases selected for sampling. This would require the contractor to provide the States with the samples after sampling has occurred, and to maintain regular contact with the selected States to insure that provider information is accurate. **Recommendation: Generate the expectation that the contractor and States will have systematic and regular contact and communication for the duration of the project. This may require a greater State effort than the current 1630 hour estimate.** States are required to reprice claims the contractor determines to be in error. This provision implies that both the contractor and the State maintain a tracking system for the claims in the sample. In order for dual tracking systems to operate successfully, regular contact and communication between contractor and State is necessary. **Recommendation: Generate the expectation that the contractor and States will have systematic and**

Section	Topic	Comments
		regular contact and communication for the duration of the project. This may require a greater State effort than the current 1630 hour estimate. States are required to reprice claims the contractor determines to be in error. There is no mention of appeal of the contractor's decision, either by the State or the provider. As experience in 3 years of PAM participation demonstrated, there is considerable room for judgment and opinion in medical necessity determinations and medical policy application. **Recommendation: States be given the opportunity to re-review ALL claims the contractor determines to be in error, and that the contractor and the State come to agreement about all claims in error PRIOR TO the recovery of any overpayments.** States are required to report to the contractor any changes of status for claims in the sample. This would again require both the State and the contractor to maintain a tracking system for sampled claims, and regular contact and communication to validate the status of claims in the separately-maintained systems. **Recommendation: Generate the expectation that the contractor and States will have systematic and regular contact and communication for the duration of the project. This may require a greater State effort than the current 1630 hour estimate.** Selected States would be required to report on corrective actions annually. This requirement, as stated, would require reporting for each year, not just the year the State participated in the project. **Recommendation: Clarify the reporting requirements for corrective actions.** This corrective action reporting requirement does not specify who designs the corrective actions. Is it the contractor or the State? Will there be fines or fees for those States who do not meet corrective action goals? **Recommendation: Clarify the source, and the consequences, of the corrective actions component.** States are required to provide technical assistance as

Section	Topic	Comments
		needed to the contractor. We are eager to provide technical assistance to the contractor. However, given the scale and complexity of Medicaid and SCHIP payment systems, appropriate and thorough technical assistance could require State effort that would exceed the estimate of 1630 hours. **Recommendation: Generate the expectation that the contractor and States will have systematic and regular contact and communication for the duration of the project. This may require a greater State effort than the current 1630 hour estimate.**
V	**COLLECTION of INFORMATION REQUIREMENTS**	
	Collection of Information Requirements	Comment: According to the requirements of the interim rule, selected States must: a) Provide a year's worth of claim data and expenditures; b) Provide, quarterly, a year's worth of adjudicated and paid claims, stratified according to CMS requirements; c) Provide all current applicable medical policies, and policy revisions quarterly; d) Provide applicable systems manuals; e) Update and verify provider contact information; f) Develop and maintain a tracking system for sampled claims; g) Reprice claims determined to be in error; h) Alert the contractor to changes in claim status for sampled claims; i) Develop, track, and report on corrective actions; and j) Provide technical assistance as needed to the contractor. These functions are all important and must be accomplished in order to effect the accuracy and efficiency of the PERM project. The estimated effort on the State's part is 1630 hours. To accomplish all these functions thoroughly, accurately, and timely, and to maintain effective communication with the contractor, States may well require considerably more than the

Section	Topic	Comments
		estimated 1630 hours. Our experience in 4 years of PAM and PERM participation has shown that these functions have consistently required 4000 – 5000 hours of state effort.

Submitter : **Mr. Claude Singleton** **Date: 11/04/2005**

Organization : **NJDHS/DMAHS/BQC**

Category : **Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment: cover letter & 6 pages of comments

CMS-6026-IFC-17-Attach-1.DOC

CMS-6026-IFC-17-Attach-2.DOC

Submitter : Christine Bronson **Date:** 11/04/2005

Organization : Minnesota Department of Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter : **Ms. Jeanne Siroky** **Date: 11/04/2005**

Organization : **Division of Medicaid**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

Please See Attachment

CMS-6026-IFC-19-Attach-1.DOC

IDAHO DEPARTMENT OF HEALTH & WELFARE

DIRK KEMPTHORNE
Governor
KARL B. KURTZ
Director

David A. Rogers-Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036

November 4, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8012
Baltimore, MD 21244-8012

Attention: CMS-6026-IFC

Dear Sir/Madam:

The State of Idaho, Department of Health and Welfare, respectfully submits comments on the Interim Final Rule regarding Payment Error Rate Measurement (CMS-6026-IFC) published in the Federal Register on October 5, 2005.

For the past two years, Idaho has participated in the Payment Accuracy Measurement and Payment Error Rate Measurement pilots. We have learned and benefited by participating in these cooperative projects with CMS. While Idaho would prefer to be fully funded to conduct the medical and processing reviews at the State level, we acknowledge that a federal contractor will be conducting the reviews this year, and if selected we will assist the contractor in any way necessary to produce complete, accurate results.

We appreciate the fact that CMS has listened to the States' concerns about the sampling methodology. It is good to know that no State will be unduly burdened by being selected more that once in three years for each program.

Idaho is committed to providing the right service at the right price for our participants while ensuring that we minimize any errors. We look forward to working with CMS and their contractors toward this goal.

Thank you for your consideration of our comments.

Sincerely,

RANDY MAY
Deputy Administrator

CM:jm

Enclosure

Cc: Kathy Lee
Greg Kunz
DeeAnne Moore

Idaho Comments to the Interim Final Rule
Federal Register on October 5, 2005
(CMS-6026-IFC)

General Comments:

1. Our first comment regards States' required participation in fulfilling a federal obligation that was assigned to federal agencies by Congress. Even with the current model of using a federal contractor, there will still be a need for significant State participation. We believe that the States' participation should be fully funded by CMS.

2. Additionally, we believe there must be sufficient lead time provided to allow the state to get additional manpower authorization to support this activity. Idaho, like many other states, has a manpower cap on the number of authorized positions funded by the legislature. If we are to take on additional work—we need additional personnel to do so—and must involve our legislature in the approval of and funding (assuming no full federal funding) of those additional positions. This requires--at a minimum—six to eight months lead time.

3. Our next general comment regards the use of a federal contractor to conduct the medical and processing reviews. It appears that a parallel has been drawn between the use of a federal contractor to conduct reviews in the Medicare program and the proposal to use a federal contractor in the Medicaid program. Medicare is a single program offering similar services to a similar population throughout the country. It is not possible to draw a parallel between the services provided by Medicare and the services provided by 50 different State Medicaid programs and fifty different SCHIP programs offering a multitude of different services administered in hundreds of different ways and utilizing incredibly complicated computer systems that are also different in each of the fifty States. Our experience has shown that the people doing the reviews must be expert in the policy, the policy application, and the claims processing system.

4. The technical assistance alone that is necessary for States to provide will be significant. We have concerns that there is no incentive for a federal contractor to put in adequate time to make sure that the results they report are accurate, that they have obtained all necessary documentation from the provider, fully researched the right Medicaid policy, checked and understood the correct screen in MMIS, etc. We are also concerned that the level of effort to correct any erroneous assumptions or assessments by the federal contractor could place a significant burden on the state.

Our remaining comments are written below with the corresponding references.

Section III. Analysis and Response to Public Comments on the Proposed Rule.
Part D. Review Procedures,

Item 1. Medical Reviews.

1. In the comment section, it is stated, *"Since the States are not performing the medical reviews, it is no longer necessary to define or clarify review procedures."* Idaho strongly disagrees with this statement as well as the following two responses that essentially say that the States do not need to know how the contractor is conducting their reviews. What the contractor does has a direct impact on the States. It is the State that will be expected to write, implement, and monitor a Corrective Action Plan that will improve error rates. Without a clear understanding of what type of criteria the

contractor is using, fulfilling the States' responsibilities will be difficult at best. We believe that the guidance already developed cooperatively with CMS and the States should be utilized along with nationally recognized medical review criteria.

2. The next two comments had to do with contacting providers and what to do about "no-response" providers. The CMS response says that this comment was no longer relevant since the States will not be doing the reviews. However, it is relevant to the States. Their error rate can be directly impacted by the level of effort the contractor puts into contacting the provider. A month after our first request letters were sent out, we had a 20% no-response rate. Through numerous additional phone calls and faxes, we were able to totally eliminate the none-responders and had a 100% response rate. We believe that it is essential for CMS to ensure that the contractor makes every effort to obtain the necessary and complete records.

3. One way to optimize the record return would be to notify States with a list of the entire sample as soon as it is made available to the contractor. States could inform and educate providers that they would soon be contacted by an outside entity, and send records as soon as possible. After 30 days the State could be contacted by the contractor and given the opportunity to assist in obtaining records. To do otherwise will result in artificially high error rates.

Item 3. Eligibility

1. Clearly the interim final rules are not meant to address specific characteristics of the eligibility review process. However, there are still concerns that need to be addressed by the joint CMS-State eligibility workgroup.

A. No State with experience working with the most recent eligibility review process has been asked to collaborate with CMS on the final model that will be used for the final eligibility review process for the MER.

B. The currently defined eligibility review process is time and staff intensive. States must have legislative authority to create and fund new positions. It is imperative that the final eligibility review rules be formulated and published as quickly as possible to give States the necessary time.

C. Eligibility reviews require qualified staff. Could the MER reviews be substituted for the MEQC or PEERS reviews in years when a State is selected to participate in MER. We recognize that MEQC & MER have different methodologies, are in separate areas of the law. We believe that it is incumbent on CMS to look at other regulations that are already in place and make every attempt to incorporate established requirements rather than overburden States with redundant policies.

D. IPIA is a congressional mandate on *federal* agencies. MER shifts that burden onto the States. The expense of these reviews should be 100% federal funds.

E. Because of the amount of time that is required to conduct an adequate eligibility review, CMS should consider making the eligibility review process exempt from the cap on SCHIP administrative funds.

F. To eliminate the multiple month reviews for individuals within a continuous eligibility period, the review requirements should be limited to the month of service only. This supports the

intent of the PERM process (to determine if the individual was eligible for the service at the time the service was provided). It also clearly highlights areas where the eligibility determination process could be improved to more accurately reflect the participants' continuing eligibility. The errors could be categorized as disqualifying or non-disqualifying depending on which eligibility factor was failed. (i.e. Income, age, residency.) Further, this generally moves the review month closer to the month in which the eligibility review itself is completed.

G. Including automatically eligible individuals in the eligibility review sample seems pointless if the PERM reviews are intended to measure an individual's eligibility in the service month. These individuals do positively affect a State's accuracy rate but can mask error-prone eligibility determination processes.

H. Again, we need to stress that the eligibility reviews are extremely time-consuming and labor-intensive. To decrease this burden, it would be prudent to continue the practice of completing eligibility reviews on a statistically valid sub-set of the claims sampled.

Section IV. Provisions of the Interim Final Rule.

1. This section describes the CMS decision to use a federal contractor to estimate medical and data processing error rates. Because of the intricacies inherent within each State's programs and systems, we would once again like to voice our preference to be fully funded to conduct the processing and medical reviews at the State level. We believe that we have the ability to conduct those reviews more efficiently, more accurately, and at a lower cost than a federal contractor is able to do. There is also a great deal to be learned about the way Medicaid programs are working. This opportunity to learn additional ways to improve programs and save federal and state dollars will be lost.

2. That being said, we understand that the federal contractor will be conducting those reviews this year, and we will work closely with the contractor to ensure accurate results. We are concerned, however, about the silence in the rule regarding any State participation in ensuring the accuracy of those reviews.

3. In this Interim Final Rule, there is no opportunity for States to review claims determined to be in error by the contractor. As CMS has acknowledged throughout the PAM/PERM pilots, States have a great deal of flexibility in the administration of their Medicaid programs, and the various MMIS systems are incredibly complex. There will be times when State input is crucial in determining whether – or not – a claim should be classified as an error. The rule should state in no uncertain terms how and when the contractor will be able to validate the errors and resolve any discrepancies with the States.

4. Later in Section IV, there is a list of activities that the States will be required to complete as part of the MER. Following this list is the statement, "States selected for review also will provide technical assistance as needed to allow the contractor to fully and effectively perform all functions necessary to produce the program error rates."

If this allows for the review of errors and input from the State in determining if an error truly exists, this is a vital role for the States to have, and Idaho supports this concept. However, later in this publication, under the Regulatory Impact Statement, the "technical assist" piece is not mentioned, and

in the rule itself, there is no mention of technical assistance. If this technical assistance is a requirement or expectation, those expectations should be expressed more clearly.

Section V. Collection of Information Requirements.

1. We did comment on this section earlier, but would like to reiterate briefly here. For those States selected for review, it will take a significant amount of time and research to accurately and completely garner all the necessary data and information into a usable format, and then transfer that information to the contractor. For smaller States such as Idaho, every new requirement impacts our budget, and we have less ability to absorb added expenses.

2. State Medicaid programs are dependent on the State Legislatures for funding. The sooner a State can learn of their selection for participation in MER, and the more clearly the State responsibilities are declared, the more effective and timely will be their response.

S 457.720

1. This part of the rule contains a list of State responsibilities. In the comments, Section IV, Provisions of the Interim Final Rule, it states that selected States will need to "provide technical assistance" as needed "to allow the contractor to fully and effectively perform all functions necessary to produce the program error rates". This is an important piece of the States' responsibilities, and if it is to be expected of the States to provide that assistance to the contractor, it should also be in the rule.

Submitter : **Christine Bronson** **Date: 11/04/2005**

Organization : **Minnesota Department of Human Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-6026-IFC-20-Attach-1.DOC

Minnesota Department of **Human Services**

November 4, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
(Transmitted via CMS E-Comment)

Re: CMS-6026-IFC

To Whom It May Concern:

Thank you for the opportunity to comment on the interim final rule governing measurement of payment error in the S-CHIP and Medicaid Programs.

I would very much appreciate the opportunity to participate in the workgroup you convene to determine the future process for determining eligibility error, as well as any discussions about the methodology and procedures for calculating error in managed care.

In general, we are very concerned about the potential for determinations of payment error in situations in which a provider does not fully cooperate with the contractor and does not provide complete records. Because we assume some providers will have little interest in the accuracy of Medicaid error rates, we think it is imperative that states are given early notice of a non-response or an inadequate record production. With that notice, states would have the option of working with the provider to ensure that the contractor has the full record for review.

We are also concerned that the interim final regulation does not provide the state with the opportunity to rebut the contractor's calculation of the state-specific error rate. We understand that a provider has an independent right to appeal the state's recovery of an overpayment, and that the state would have the opportunity to appeal any disallowance if it failed to recover an overpayment. However, the state has no right under the new regulation to contest the determination of a specific error, or the error rate itself. Because the states and CMS have a strong interest in an error rate that is as accurate as possible, it is imperative that CMS afford the state with notice and an opportunity to review and respond to the proposed findings, before final publication.

In addition, §431.970, paragraph (h) provides that states must submit to CMS "...A corrective action report *as prescribed by the Secretary* for purposes of reducing the payment error rate." Emphasis added. This could be interpreted to require states to take any corrective action demanded by the Secretary,

whether or not the demand is supported by existing authority under federal law. This paragraph should be revised to provide:

> ...a corrective action report that addresses significant issues identified by the Secretary, at times and in a format prescribed by the Secretary."

Similarly, §431.971, paragraph (g) requires states to provide "...other information that the Secretary deems necessary for, *among other purposes*, estimating improper payments and determining error rates." This interim final regulation is intended to govern only estimating improper payments and error rates. CMS has other general authority under federal law to demand information necessary for the administration of the Medicaid program. The phrase "among other purposes" is not within CMS' authority under the Improper Payments Information Act of 2002, is unnecessary, and should be deleted.

We also remain concerned about the very broad definition of "improper payment." While we understand that a provider's inadequate documentation in a medical record is of concern and should be measured, the inclusion of any documentation error as an improper payment will produce a higher error rate in states that are the most demanding in their documentation requirements. CMS could alleviate this concern somewhat by including, in its final report, a comprehensive explanation of what is included as payment error.

Finally, we remain concerned about the validity of the proposed sampling plan and methodology for calculating state-specific error rates. We strongly recommend that CMS engage a qualified review organization, independent from the PERM contractor, to evaluate the sampling strategy and error rate formulas.

Specifically, our concerns pertain to the proposed plan for stratifying the sample of claims, and the strategy for weighting the findings within the strata. If unchanged, these methods will produce invalid estimates of state-specific error.

The proposed strata are neither mutually exclusive nor representative across all Medicaid programs. We recommend using a systematic random sampling methodology in which claims are ordered before the sample is drawn. That method would accomplish maximum precision given the wide variation in the Medicaid benefits provided by the states, and the corresponding variations in claims processing procedures. This approach also eliminates the need for weighting the findings of each strata's claim reviews and aggregating those individual, error-prone statistics into a calculation of single error rates for each state.

As an alternative to using a systematic random sampling methodology, CMS might consider reducing the number of strata. There seems to be considerable confusion and overlap between the groupings, especially between the "independent practitioners or clinics" group, and "other services," and between "home and community-based services" and "other services."

Again, thank you for the opportunity to comment on the interim final regulation, and I look forward to our continued work in developing the methodologies for determining eligibility error and payment error for managed care claims.

Sincerely,

/s/

Christine Bronson
Medicaid Director

Submitter : Mr. Alan White

Date: 11/04/2005

Organization : National Assn. of SURS Officials

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

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

Submitter : Mr. Alan White **Date:** 11/04/2005

Organization : National Assoc. of SURS Officials

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-6026-IFC-22-Attach-1.DOC

ENSURING MEDICAID
PROGRAM INTEGRITY

November 3, 2005

Ms. Janet E. Reichert
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC
PO Box 8012
Baltimore, MD 21244-8012

Ms. Christine Jones
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC
PO Box 8012
Baltimore, MD 21244-8012

Dear Ms. Reichert and Ms. Jones:

On behalf of the National Association of Surveillance and Utilization Review Officials (NASO) I would like to thank you for the opportunity to provide comments related to the "Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement" final interim regulations published by CMS in the October 5, 2005 edition of the *Federal Register*.

As we stated in our earlier comments on the proposed rule we understand the importance strong program integrity efforts play in assuring that Medicaid funds are channeled appropriately, and we, therefore, support efforts to identify any misuse of those funds and endorse efforts to help states improve the effectiveness of their program integrity function. We also very much appreciate the work that has been put forth by the Centers for Medicare and Medicaid Services (CMS) to assist states in our work. The current proposal has incorporated many of the suggestions proffered in response to the proposed rules, so we are also grateful to see that CMS acknowledged the concerns expressed by our organization and the many others who commented on those proposed rules.

Although we appreciate the inclusion of some of our suggestions there are still several issues that we believe need to be addressed prior to the implementation of the PERM program. It is also our belief that due to the limited amount of information contained in the proposed regulations and the CMS Notice of Proposed Information Collection, it is impossible for states to determine the full and complete impact that this initiative will have on state resources. Therefore, we respectfully submit the following comments based on the information that is currently available and request that additional input from the states be sought prior to the initiation of PERM collection activities.

1. **State-specific error rates are unnecessary and costly**

The Improper Payments Information Act of 2002 requires federal agencies to annually review and identify programs that may be susceptible to significant erroneous payments, estimate the amount of improper payments and report those estimates to the Congress. If necessary, agencies must also report the actions being taken to reduce erroneous payments. The intended result of this proposed rule is to identify opportunities for reducing the rate of improper payments and increasing program savings at both the state and federal levels.

As many responders have also previously stated, we believe that the Act requires that the Department of Health & Human Services (HHS) establish a nationwide federal improper payment rate. To the best of our reading, there is no requirement in the Act that CMS establish a specific error rate for each state. Therefore, we would suggest that the federal contractor select a nationwide statistical sample then review those claims with the assistance of the individual state. While the use of a federal contractor will reduce the need for additional state staff, we believe that a cooperative effort between the State and the federal contractor will be the most effective method of obtaining the documentation necessary to support the appropriateness of the Medicaid payment. In the earlier proposed PERM regulation, CMS justified the use of the states' workforce because they are the only ones with the expertise to determine if a Medicaid or SCHIP claim has been paid properly. On this we do not disagree. However, we did not agree with the states having to bear the costs of the reviews.

Therefore we would suggest that if CMS wishes to proceed with the current PERM regulation, it should utilize the expertise and cache of the State Medicaid agency to assist the federal contractor, and fund the additional state resources with 100% federal dollars.

2. **Appeal processes must be clearly defined and easily accessible to states**

Staffing costs associated with the anticipated need to reconcile or appeal the decision of the federal contractor will be higher than projected because the complexity and volume of work requires a large, knowledgeable staff dedicated to these issues, including nurses, peer consultants (pharmacists, doctors, etc.), statisticians, and system staff. However, because of the lack of definitive information relating to the process for any appeal or reconciliation it is impossible to estimate the additional resources that would be required.

We also believe that the process by which a state may challenge the contractor's determination that an error has occurred needs to be more thoroughly defined. All of the information that has been presented indicates that CMS is anticipating re-payment from the states of federal funds related to the claim identified as an error. However, if the states are expected to recover the amount of the error from the provider, they will need to utilize the methods currently in existence for that purpose. In most, if not all states, this would include giving the provider the right to appeal the re-payment request to an Administrative Law Judge. The state cannot rely on the contractor's determination as the sole reason for collection of an overpayment. Therefore, the state must conduct its own investigation to determine if the actions of the provider actually created an overpayment.
Accordingly we would assume that the date of discovery of such overpayments would be the date that the state agency confirms that an overpayment occurred, rather than the date the contractor specified that an error had occurred.

3. Denied claims should not be included in the PERM rate calculations

Another area of concern to our members is the inclusion of denied claims in the determination of a state's error rate. While we understand the CMS interpretation of the IPIA on this issue, we still maintain our position that including underpayments and denied claims creates an untrue picture of state payment controls. Under the proposed guidelines, the payment error rate is to be calculated by adding overpayments and underpayments, not by offsetting overpayments by underpayments. Adding underpayments to overpayments will count unspent dollars (underpayments) as misspent money. If the intended purpose of PERM is to identify improper payments, then by the definition in the law, a denied claim that results in no payment should not be considered improper.

4. **To be accurate, a nationally contracted vendor will need to work closely with state experts during the audit. State time is likely to be substantial and should be reimbursed.**

Based on our collective experience, we also believe that the learning curve associated with the use of a nationwide contractor(s) will be a critical element in the success or failure of this initiative, and while we appreciate CMS' response to our request to involve a national contractor, we must also relate the following concerns that are created by that approach:

- Unlike Medicare which basically uses one set of program guidelines, for Medicaid 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 basics of these issues and then each state produces volumes of materials including manuals, updates, bulletins, provider letters, etc... to refine and explain its polices. The ability of the contractor to collect and understand the tremendous volume of informational materials relating to a state's payment and coverage policies will be extremely difficult and time consuming.
- The need for additional follow-up information related to claims payment (prior authorization, TPL, pre-payment safeguards, post-payment adjustments, etc...) will require additional time and resources from both the state agency and potentially the state's Medicaid fiscal agent.

- Every state we contacted that participated in the PAM or PERM pilots identified medical record collection as one of the most significant and time consuming tasks they encountered during the pilot. Obtaining a complete and accurate record required, not only several letters to providers, but also follow-up phone calls and in some cases on site visits to the provider. In many cases, merely identifying the appropriate office of individual responsible for maintaining the medical records required significant time and effort. If it is anticipated that the state will be responsible for performing this task, additional resources will, again, be required. Once the record was located, the need to verify the accuracy and completeness of the record required additional staff time and costs. We believe that the task of record collection will be even more time consuming for the national contractor because of the lack of an existing relationship between the contractor and the state's provider network. In the pilots, there was an awareness of the state's authority to request records and the provider's obligation to submit them. The same will not be true when an unfamiliar contractor approaches providers and requests records that the providers may be reluctant or hesitant to release. That will obviously hinder the ability of the contractor to obtain the records within the proposed timeframe. We therefore fear, that lacking the state's incentive to pursue collection of the record, the contractor will not show the same diligence as the state in obtaining the record and the result will be a higher error rate than would exist if the state played an active role in the collection process.

5. CMS should create a Steering Committee to provide input and guidance during the implementation phase of the final regulations

To assist with the development of some resolution to these issues, and the many other similar issues that are sure to be raised by other commenters, we would suggest that CMS consider the creation of an advisory steering committee, composed of federal and state officials to assist the federal contractor as it attempts to understand the environment in which states operate and the various obstacles that the contractor will encounter.

For a variety of reasons, we cannot overemphasize the need for close coordination between the federal contractor and the state agency in all PERM activities. From the notification to the providers, through the collection of records, to the determination of an error, and subsequently when necessary the appeal of a determination of error, the involvement of the state is critical to the assurance that PERM findings are accurate, consistent and valid.

There is one final issue I would like to mention. As we all realize, the statistical probability that a state will perform its payment process without error will rarely be 100%, but what also needs to be understood is that the probability of a PERM error increases with each safeguard that a state adds to its payment process. Therefore, I think that it would be truly unfortunate if one of the outcomes of PERM would be casting a negative light on states that had been aggressive in their efforts to protect the integrity of their payment system.

Once again, we would like to thank you for the opportunity to comment on this proposal. The implementation of these regulations will have a great impact on all of our programs, so we would hope that we could work together with you to ensure an outcome that benefits all of us. We hope that these suggestions will be of use to you, and we hope that you will not hesitate to contact us

if you have questions regarding our comments, or if our association or any of our members can be of any assistance to you.

Sincerely,

Alan S. White, President
P.O. Box 309
Madison WI 53701

Submitter : **Beth Waldman** **Date: 11/04/2005**

Organization : **Massachusetts Office of Medicaid**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC-23-Attach-1.DOC

November 4, 2005

Dr. Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-6026-IFC
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Comments on Medicaid and State Children's Health Insurance Program Payment Error Rate Measurement Interim Final Rule File Code CMS-6026-IFC

Dear Dr. McClellan:

The Commonwealth of Massachusetts appreciates the opportunity to submit comments on the Interim Final Rule regarding Payment Error Rate Measurement (PERM) in the Medicaid and State Children's Health Insurance Programs.

We agree with the revision in the interim final rule which modifies the August 27, 2004 approach by requiring a federal contractor to measure the improper payments and providing for a phased implementation of the requirement.

While CMS plans to hire a contractor(s) to complete the data processing and medical reviews and calculate the State specific error rates, States will still be required to assist in the process by providing time, resources and effort to support the project with State subject matter experts for planning, orientation, sampling, coordination and error determination. A contractor's learning curve should not be underestimated. Each State has a unique program and will need to provide subject matter experts to assist contractors in developing a general and specific understanding of each State's program.

Accordingly, where the Improper Payments Information Act (IPEA) requires Federal agencies to annually estimate and report to Congress, we believe that CMS should properly compensate States at 100 % FFP for the State's time. The delegation of the responsibility for this work without adequate funding is overly burdensome and unfair.

Comments on Analysis and Response to Public Comments on the Proposed Rule

There remain a number of other practical matters that need attention and that are critical to the efficient and accurate implementation of the PERM requirements. We will address these in several categories:

- Section III.C. Claims Universe and Sampling
    - Denied claims where no payment was made should be excluded from sample. As noted in your response to comments, "The IPIA defines improper payment as "*any payment that should not have been made or that was made* in an incorrect amount including overpayments and under payments." Accordingly, an improper payment requires a payment having been made.

    - Providers under audit and investigation should also be excluded. Where an ongoing audit exists, removal of one claim may result in challenges to the State's sampling methodology and ability to extrapolate the results. Further where a State suspects fraud and has referred the matter to the Medicaid Fraud Control Unit or other law enforcement authorities, as required under federal law, a State may have intentionally not initiated any action to recover any overpayments in order not to interfere with any ongoing criminal investigation.

- III.C.3. Overpayment and Underpayment Errors
    - A true error rate can only be determined by identifying overpayments and underpayment, and offsetting or netting one against the other to determine the sum of errors.
    - Aggregating overpayments and underpayments provides a false indication of overpayments and payment error and distorts results.

- III.D. Review Procedures
    - States should not be penalized because of non-responsive providers who fail to produce records or respond to follow up questions.
    - What happens if the PERM contractor is unable to obtain documentation from providers?
    - Contractor determined errors should be validated by the State prior to being reported as errors.

- III.G Appeals
    - How will transaction errors be handled when a provider appeals an error and the State has an appeal process that is not exhausted prior to the completion of the PERM audit?

- Draft Report
    - States should receive a copy of draft report for their State and be provided with an opportunity to respond within 30 days prior to publication.

- Final Report
    - How will the report be presented?
    - How will State performance be presented in a way that provides for accurate representation of both a national rate with an understanding of each State's performance?

Fundamental concerns with the PERM process.

As we previously mentioned:

While the intended effect of the Interim Final Rule is for States to assist the federal contractor in the development of a national improper payment estimate and to identify existing vulnerabilities that can be addressed, we believe there are more effective and accurate ways to approach the identification of vulnerabilities and necessary corrective action. Implementing the requirements of PERM as described in the Interim Final Rule will undeniably compete with State resources directed toward other more promising quality control projects such as internal control reviews and risk assessments, internal and provider audits, program integrity and fraud and abuse initiatives, utilization review, quality control projects and Medicaid Management Information System audits.

The likelihood of achieving an accurate national error rate, by aggregating error rates from all of the States with their inherent varieties, is questionable.

While the proposed revisions allowing for a phased implementation of agencies and scope help, the implementation of the Interim Final Rule remains daunting.

Comments on Interim Final Rule

Section 431.958, Definitions:

The definition of terms governs the operation and outcomes of the project. While most of the definitions in the Proposed Rule have been removed from the Interim Final Rule, we have some concerns with the remaining definitions and make the following comments for purposes of clarification and establishing fairness in the PERM process.

> *Payment error rate* remains defined as the sum of the overpayments and underpayments as an absolute value rather than the net of the two. This artificially inflates the errors and the error rate. We recommend that the errors be counted as the net of underpayments and overpayments.

Comments on Collection of Information Requirements

Time and Resources needed for PERM Implementation

We believe that CMS has grossly underestimated the time and resources needed to conduct the PERM process. The summary discussion of estimates in the Proposed Rule does not incorporate the appropriate sample sizes, the expanded scope of PERM or other tasks. As a result, we believe that the estimates are understated.

The costs associated with planning, organizing, developing procedures, developing the universe, sample plans and sample, administering, reporting, following up and record keeping activities are also not sufficiently addressed.

Duplication of existing efforts

More troubling, PERM, which through PAM has not been shown to result in findings of high overpayments, could take away resources from other State programs, which are more likely to find improper payments.

In closing, while we appreciate the Federal government's reliance on States for expertise in Medicaid and SCHIP program administration, we object to the imposition of a portion of the financial responsibility for implementing the IPIA being shifted to States. To address this concern the States' expenses should receive a 100% administrative match and there should be no cap on State administrative claims for the PERM process.

Thank you for considering our comments and concerns. We look forward to receiving the Final Rule and to continuing to work with CMS to ensure successful implementation of the Payment Error Rate Measurement.

Sincerely,

Beth Waldman
Medicaid Director, Massachusetts

Submitter : **Ms. Anne Marie Murphy** **Date: 11/04/2005**

Organization : **Illinois Dept. of Healthcare and Family Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

Docket Number: CMS-6026-IFC - Payment Error Rate Measurement (PERM) Program:

Comments from Illinois Department of Healthcare and Family Services, Division of Medical Programs are attached in Microsoft Word Format.

CMS-6026-IFC-24-Attach-1.DOC

ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

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November 4, 2005

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

Dear Sir or Madam:

Thank you for this opportunity to comment on the "Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement" final interim regulations published by CMS in the October 5, 2005 edition of the *Federal Register*.

The Illinois Department of Healthcare and Family Services, which administers Medicaid and the State Children's Health Insurance Program (SCHIP) in Illinois appreciates the opportunity to comment on the interim final rule for Payment Error Rate (PERM) review. Illinois strongly supports valid payment accuracy measurement. We were the first state to perform a payment accuracy review and to institute an ongoing measurement effort.

We recognize the progress made by the Centers for Medicare and Medicaid Services (CMS) in developing the PERM regulations and understand the significant challenges that CMS faces. We believe that your agency made the right decision to use the services of one or more contractors to conduct the PERM review – not only because it greatly reduces the burdens imposed on states but also because it will ensure greater across-state consistency and reliability in the review process and outcome.

In the interim final rule CMS asked for input on the eligibility review but indicated that reliance on the MEQC review to provide an eligibility accuracy estimate is not an option. Given that, we believe that your agency should consider reviewing a small sub-sample of the recipients whose services were selected in PERM. We suggest also that the as part of the review, the administrative period policy be applicable to eligibility determinations; failure to do so will result in an artificially inflated eligibility error rate. We believe that use of a sub-sample and proper consideration of the administrative period policy will provide a reliable estimate of the recipient eligibility errors without overwhelming the federal contractor assigned to perform this review.

CMS' plan to rely on a national contractor to perform the claims review component of PERM provides cross-state consistency and reliability and places the burden of meeting the requirements of the Improper Payment Information Act on the federal government, which is what Congress had intended. We suggest

that CMS use this same approach to complete the eligibility review – employ a national contractor. The result will be greater consistency – both across states and components of the PERM review. We believe there are significant resource implications whether the national contractor reviews every recipient selected for review in the PERM sample, reviews a sub-sample of recipients selected for review in PERM, or uses MEQC-based estimates; we are not convinced there are significant accuracy differences in these methods.

We do feel strongly, though, that since the federal government is ultimately making this decision it and its contractor(s) must be responsible for the resource and logistical implications this choice.

Beyond the eligibility review, we have significant concern that the PERM regulations do not provide a process for states to review the contractor's results to ensure the review's accuracy. Medicaid and SCHIP payment and billing policies are complex, vary by state, and sometimes vary by program within a state, and the contractor will benefit from a formal review of the payment accuracy error results. A misunderstanding of state reimbursement or billing policies on the contractor's part will results in an inaccurate review, erroneous payment accuracy estimates, and states' inability to develop or implement corrective action plans that are meaningful. While PERM is a federal initiative, we expect that states will have an opportunity to formally review each error record with the contractor before a final set of state-specific or national estimates are made.

We also are concerned that the interim final rule does not reveal major methodological or procedural aspects of the review. For example, we are uncertain how many times the federal contractor will attempt to contact a provider, whether they will consider non-response by the provider to be an error, and if so, whether states will have an opportunity to assist the contractor in obtaining the provider's compliance. If the PERM review will be a useful tool for program integrity monitoring and will be trusted by Congress, OMB, the public, providers, and states, its methodological specifics and procedures need to be described in the rule or a subsequent guidance document and be subject to public comment and discussion.

Finally, we believe the rule could be strengthened by specifying in greater detail the precise data and information requirements that states are expected to provide to the contractor, along with more detail on the schedule for the provision of this information.

HFS appreciates the opportunity to comment on the regulations. We offer our services to your agency in creating this PERM model. Thank you for your time and attention in this matter.

Sincerely,

Anne Marie Murphy

Anne Marie Murphy, Ph.D.
Medicaid Director

Submitter : **Mr. F. Blake Anderson** **Date: 11/04/2005**

Organization : **Dept. of Health/HCF/CRP**

Category : **State Government**

Issue Areas/Comments

GENERAL

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November 4, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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

Dear Dr. McClellan:

In conjunction with The American Public Human Services Association (APHSA) and its affiliates, the Utah Division of Health Care Financing (DHCF) is submitting this comment letter on Medicaid and SCHIP Payment Error Rate Measurement.

DHCF is commenting on the interim final rule proposed published in the October 5, 2005, Federal Register (70 FR 58260) for the Centers for Medicare and Medicaid Services (CMS). Utah concurs with the comments submitted by APHSA on the August 2004 PERM proposed rule. APHSA criticized the overall PERM proposal as ?one that would be costly and challenging to implement and one that could yield invalid results.? APHSA also noted, ?the Improper Payments Information Act of 2002 (IPIA) did not specifically require state-level error rates, and therefore they questioned the need to implement a PERM process to produce state-level error rates.?

?APHSA and other commentators suggested CMS retain a federal contractor to conduct the nationwide PERM assessment.? As stated, ??in our comment letter dated August 22, 2005 (CMS-10166), on CMS? notice of proposed information collection, we appreciate CMS? decision to accept the recommendations of commentators and retain a federal contractor for Medicaid and SCHIP PERM.? While DHCF mostly supports the federal contractor approach for Medicaid and SCHIP PERM, we also have some concerns with some components of CMS? implementation plans as addressed by APHSA involving:

? The apparent inability, as currently defined in the regulations, for states to actively participate in the rule making process, particularly for development of the eligibility and managed care components of PERM;
? The need for a clear process to enable states to re-review PERM contractor error findings; and
? more opportunity for input in the development of and monitoring of PERM contractors? work plans, work statements, and protocols.

DHCF also has several concerns regarding the burden that may be placed on states selected for PERM review. APHSA has also noted these same concerns:

? If Utah is selected for PERM review we will be required to submit to the federal contractor annual Medicaid and/or SCHIP expenditures and quarterly stratified claims data which is an additional burden. The stratification of quarterly claims data by the individual states selected for PERM could result in errors and inconsistencies between state PERM estimates. APHSA encourages and DHCF concurs that ?CMS should have the federal contractor conduct the quarterly claims stratification to ensure consistency across states and from quarter to quarter.?

? CMS should be required to enter into a dialogue with states to identify the components of model corrective action plans so that these can be refined and agreed upon before the PERM information collection process begins. CMS should establish a steering committee or other advisory group including, where possible, state representatives to help ensure that the PERM contractors consider all the logistical issues and address all potential data collection issues before beginning their onsite and interactive work with states in collecting medical review policies, manuals, and system documentation. If state representatives have the opportunity to participate through an advisory or other steering committee, DHCF might be able to assist in reducing the ?steep learning curve? facing federal PERM contractors and thereby reducing demands on DHCF state staff to support the PERM contractors.

? Utah?s prior PAM Pilot experience (3rd year-

Submitter : **Mr. F. Blake Anderson** **Date: 11/04/2005**

Organization : **Utah Dept. of Health/HCF/CRP**

Category : **State Government**

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? Utah?s prior PAM Pilot experienc

CMS-6026-IFC-26-Attach-1.DOC

CMS-6026-IFC-26-Attach-2.DOC

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- Utah's prior PAM Pilot experience (3rd year- 2003) reported substantial staff time which is required to perform initial and follow-up training for contractors on state policies and to stay in continuous communication with them on a variety of day-to-day matters.

  As noted by APHSA, "a solution to the difficulty in estimating states' burdens is for CMS to provide 100 percent reimbursement for staff time and other expenses to comply with CMS' PERM regulations." APHSA further noted, "It seems likely the first PERM round will be the most onerous, where states essentially are transferring a large body of medical review, systems, and provider information knowledge to PERM contractors." CMS should consider additional support to DHCF during this startup phase to ensure the process is workable and DHCF and CMS are satisfied the resulting error rates are valid, consistent, fair, and accurate.

- Federal funds are clearly not used to pay denied claims, and therefore DHCF concurs along with APHSA that denied claims should be removed from the sampling universe.

- APHSA also noted, "One approach to minimizing the data collection burden may be to utilize one-year-old data by extracting Medicaid Statistical Information System data that the federal government already collects." In addition, the federal contractor will likely need more information than specified in the interim rule. To review and assess payment error accuracy, contractors will need adjudicated claims data and medical policies, as well as a number of dynamic reference files/subsystems in DHCF systems including but not limited to third-party liability, prior authorization, utilization history, processing edits, and pricing data to conduct claims audits. Providing these additional files and subsystem information to CMS' PERM contractor will require staff time, effort, and management oversight unaccounted for in the interim rule's burden estimate.

  APHSA stated, "that without considerable effort to retrieve all provider information including a near-full set of records from sampled providers, PERM contractors could overstate states' error rates. Contractors may not have enough or the right financial incentives to devote the kind of staff time necessary to retrieve near-complete sets of sampled PERM records. In PAM pilots, some of the most common errors were due to incomplete or missing documentation. States participating in PAM report that they are able to obtain nearly complete data only after repeated contacts and other follow-up with providers. It is unlikely that contractors will have the resources in their contracts to devote the kind of repeated effort necessary to obtain complete provider records or to clarify and resolve other documentation problems with providers. It is more likely that contractors will follow a data collection protocol that specifies the steps to follow in obtaining provider records, and if they fail to get documentation after following those steps, their default will be to determine the claim an error."

  DHCF urges CMS to consider "the steep learning curve that contractors will face in the first PERM reviews for each state. During these initial PERM reviews, contractors will have limited financial incentives to devote the kind of effort necessary to obtain near-complete provider records for the sampled claims."

- DHCF is concerned, "...if CMS' contractors are less persistent than our current staff in obtaining provider records, contractors could unintentionally inflate states' PERM rates. DHCF's experience participating in the PAM Pilot has shown that obtaining adequate documentation can be the most labor-intensive part of claims audits. APHSA has suggested that CMS collaborate with states to develop model letters, other processes, and guidance to ensure provider cooperation. DHCF also verifies medical necessity determinations with physicians and we encourage CMS to include this step in the contractor work plans, even though this might prove difficult in rural areas where providers can be unavailable."

- Utah is also concerned "there is no specific provision to re-review audit findings or rebut initial error determinations." DHCF may be able to explain alleged errors by reviewing the case or expending additional effort in obtaining or interpreting provider documentation. APHSA has noted, "...errors may arise from the need for insight in interpreting individual policies, and these interpretation cases could easily be resolved through a process where states are formally permitted to review all errors using the documentation collected and used

by the contractor before final error rates are established." DHCF urges CMS to explicitly develop a formal process for states to re-review all errors before final error rates are established."

- DHCF believes there should be a minimum 5% allowance for claims that can be dropped as a result of fraudulent claims or providers under active state investigation. Federal contractors should consult with states prior to contacting providers so as not to jeopardize an ongoing fraud investigation. One approach might be to exclude claims for provider under active investigation from the quarterly sample states are to submit to CMS' PERM contractor.

- DHCF concurs with APHSA "that deriving state-specific error rates goes beyond the requirements of the IPIA. The fact that state-specific error rates will be derived and then aggregated to determine a national rate makes it that much more important that states have some ability to review and validate CMS' PERM contractor findings, before a corrective action plan or state error rate is established." In addition, DHCF would like to know the formula that will be used to calculate error rates.

- DHCF urges CMS to provide 100 percent funding for additional personnel which we be required to meet the expectations of PERM. DHCF may be forced to shift staff from other budgeted resources in order to comply with and satisfy PERM requirements.

DHCF concurs with APHSA regarding several questions on the corrective action plan process. "Will the contractor or state be responsible for implementation of a corrective action plan? Who will monitor the plan's activities and evaluate its outcome? If states are to prepare and implement corrective action plans, these plans could constitute a significant workload beyond what is described in the burden section of this interim rule and previous information collection proposals." DHCF would like more information to better understand CMS' vision of the corrective action process so that we can more effectively plan for complying with the requirement.

Thank you for considering our comments.

Sincerely,

F. Blake Anderson
Director, Bureau of Coverage and Reimbursement Policy

November 4, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC
Mail Stop C4-26-05
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- CMS should be required to enter into a dialogue with states to identify the components of model corrective action plans so that these can be refined and agreed upon before the PERM information collection process begins. CMS should establish a steering committee or other advisory group including, where possible, state representatives to help ensure that the PERM contractors consider all the logistical issues and address all potential data collection issues before beginning their onsite and interactive work with states in collecting medical review policies, manuals, and system documentation. If state representatives have the opportunity to participate through an advisory or other steering committee, DHCF might be able to assist in reducing the "steep learning curve" facing federal PERM contractors and thereby reducing demands on DHCF state staff to support the PERM contractors.

- Utah's prior PAM Pilot experience (3rd year- 2003) reported substantial staff time which is required to perform initial and follow-up training for contractors on state policies and to stay in continuous communication with them on a variety of day-to-day matters.

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- APHSA also noted, "One approach to minimizing the data collection burden may be to utilize one-year-old data by extracting Medicaid Statistical Information System data that the federal government already collects." In addition, the federal contractor will likely need more information than specified in the interim rule. To review and assess payment error accuracy, contractors will need adjudicated claims data and medical policies, as well as a number of dynamic reference files/subsystems in DHCF systems including but not limited to third-party liability, prior authorization, utilization history, processing edits, and pricing data to conduct claims audits. Providing these additional files and subsystem information to CMS' PERM contractor will require staff time, effort, and management oversight unaccounted for in the interim rule's burden estimate.

  APHSA stated, "that without considerable effort to retrieve all provider information including a near-full set of records from sampled providers, PERM contractors could overstate states' error rates. Contractors may not have enough or the right financial incentives to devote the kind of staff time necessary to retrieve near-complete sets of sampled PERM records. In PAM pilots, some of the most common errors were due to incomplete or missing documentation. States participating in PAM report that they are able to obtain nearly complete data only after repeated contacts and other follow-up with providers. It is unlikely that contractors will have the resources in their contracts to devote the kind of repeated effort necessary to obtain complete provider records or to clarify and resolve other documentation problems with providers. It is more likely that contractors will follow a data collection protocol that specifies the steps to follow in obtaining provider records, and if they fail to get documentation after following those steps, their default will be to determine the claim an error."

  DHCF urges CMS to consider "the steep learning curve that contractors will face in the first PERM reviews for each state. During these initial PERM reviews, contractors will have limited financial incentives to devote the kind of effort necessary to obtain near-complete provider records for the sampled claims."

- DHCF is concerned, "...if CMS' contractors are less persistent than our current staff in obtaining provider records, contractors could unintentionally inflate states' PERM rates. DHCF's experience participating in the PAM Pilot has shown that obtaining adequate documentation can be the most labor-intensive part of claims audits. APHSA has suggested that CMS collaborate with states to develop model letters, other processes, and guidance to ensure provider cooperation. DHCF also verifies medical necessity determinations with physicians and we encourage CMS to include this step in the contractor work plans, even though this might prove difficult in rural areas where providers can be unavailable."

- Utah is also concerned "there is no specific provision to re-review audit findings or rebut initial error determinations." DHCF may be able to explain alleged errors by reviewing the case or expending additional effort in obtaining or interpreting provider documentation. APHSA has noted, "...errors may arise from the need for insight in interpreting individual policies, a nd t hese int erpretation c ases could e asily b e r esolved t hrough a p rocess w here states are formally permitted to review all errors using the documentation collected and used

by the contractor before final error rates are established." DHCF urges CMS to explicitly develop a formal process for states to re-review all errors before final error rates are established."

- DHCF believes there should be a minimum 5% allowance for claims that can be dropped as a result of fraudulent claims or providers under active state investigation. Federal contractors should consult with states prior to contacting providers so as not to jeopardize an ongoing fraud investigation. One approach might be to exclude claims for provider under active investigation from the quarterly sample states are to submit to CMS' PERM contractor.

- DHCF concurs with APHSA "that deriving state-specific error rates goes beyond the requirements of the IPIA. The fact that state-specific error rates will be derived and then aggregated to determine a national rate makes it that much more important that states have some ability to review and validate CMS' PERM contractor findings, before a corrective action plan or state error rate is established." In addition, DHCF would like to know the formula that will be used to calculate error rates.

- DHCF urges CMS to provide 100 percent funding for additional personnel which we be required to meet the expectations of PERM. DHCF may be forced to shift staff from other budgeted resources in order to comply with and satisfy PERM requirements.

DHCF concurs with APHSA regarding several questions on the corrective action plan process. "Will the contractor or state be responsible for implementation of a corrective action plan? Who will monitor the plan's activities and evaluate its outcome? If states are to prepare and implement corrective action plans, these plans could constitute a significant workload beyond what is described in the burden section of this interim rule and previous information collection proposals." DHCF would like more information to better understand CMS' vision of the corrective action process so that we can more effectively plan for complying with the requirement.

Thank you for considering our comments.

Sincerely,

F. Blake Anderson
Director, Bureau of Coverage and Reimbursement Policy

Submitter : **Ms. Ann Clemency Kohler** **Date: 11/04/2005**

Organization : **Div. of Medical Assistance and Health Services, NJ**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-6026-IFC-27-Attach-1.DOC

November 4, 2005

Centers for Medicare & Medicaid Services
U.S Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8017

ATTENTION: Christine Jones and Janet Reichert

Re: Comments to the interim final rule, "Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement (PERM)" **File Code CMS-6026-IFC**

Dear Ms. Jones and Ms. Reichert:

The New Jersey Division of Medical Assistance and Health Services (DMAHS) respectfully submits the enclosed comments in response to the notice of interim final rulemaking, "Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement" published in the Federal Register on October 5, 2005.

Although the Improper Payments Information Act of 2002 (IPIA) requires federal agencies to review, identify and estimate payment error rates, the method presented in the interim final rule shifts back only part of the burden of those reviews from the states to the Centers for Medicare and Medicaid Services (CMS). That is, although DMAHS supports the decision to have a national federal contractor conduct the claims processing and medical necessity review components of PERM, we are concerned that the amount and scope of technical assistance the contractor will need from the participating states is still uncertain and not clearly delineated. We are also concerned that the eligibility review component of PERM, to be implemented in FFY 07 as a state responsibility, will be costly and will inherently duplicate Medicaid Eligibility Quality Control activities. In addition, we are concerned about the vagueness of the disputed findings resolution process and the decision to skew the PERM calculation with non-payment errors.

New Jersey believes that, although state involvement is essential to CMS's satisfying the IPIA reporting requirements, CMS has underestimated the time, extent and cost of that involvement. We therefore believe that CMS should cover 100% of the state participation costs because the IPIA requirements are first and foremost a federal responsibility.

Our comments, questions and recommendations are enclosed. We respectfully request that the interim final rule, and CMS's explanation of them, be modified in accordance with our comments, questions and recommendations.

Sincerely,

Douglas Mc Gruther, for
Ann Clemency Kohler
Director

Enclosure

Section I: Background

- In addition to providing estimated improper Medicaid and SCHIP payment levels, CMS must set targets for future improper payment levels and a timeline by which the targets will be reached.

  1) Will CMS set an arbitrary target level or use baseline empirical data, when available?

  2) Will each State be measured against its individual past performance or a national average?

  3) The interim final regulations, like the proposed regulations, do not mention any ramifications if target error rate estimates are not met. What are the incentives for having a lower error rate estimate or disincentives for a higher estimate?

  4) There are statements throughout the notice of interim final rule with comment period that participation will result in minimal imposition on State resources. What recourse will a State have if, due to understated CMS cost estimates coupled with the State's budgetary constraints, it is unable to satisfy its PERM process obligations?

Section II: Provisions of the Proposed Rule

- An intended effect of the proposed rules was to have States measure improper payments and to take needed corrective actions that increase program savings at both the State and Federal levels.

  1) The IPIA does not require States to report an estimate of improper payments to Congress as evidenced by CMS' decision to use a Federal contractor to produce the error rates. However, the contractor's operational success is heavily contingent on information and technical assistance provided by the participating States.

  2) Since the eligibility component of the PERM has yet to be developed, we feel it is premature to conclude that the impact on State resources will be minimal.

  3) CMS intends to implement the eligibility component of the PERM within existing Medicaid and SCHIP laws and regulations. Does this mean that 42 CFR 431 subpart P will be revised so as to substitute the existing MEQC requirements with PERM eligibility requirements? If true, it will eliminate duplication of effort and enable States to convert MEQC resources to PERM eligibility resources.

  4) At what point will states that have low error rate estimates be exempt from submitting a corrective action plan or participating in PERM? New Jersey

believes that States with low error rates should be given the same consideration offered through MEQC – to develop and operate pilot projects that improve program performance. Through the flexibility of Medicaid pilot projects, New Jersey has been proactive in identifying and resolving a variety of both payment and eligibility issues that have improved program administration. Medicaid pilot projects allow States to concentrate on identified problems and are a much better use of limited resources.

5) New Jersey has not participated in the PAM/PERM projects; however, it is our understanding that a high percentage of improper payments were due to "lack of documentation" errors; and that, if the documentation were provided, it is possible that the error findings would decrease. Regarding eligibility samples, based on experience, we do not feel that we need to review caseloads larger than selected in traditional MEQC to identify and address problem areas.

6) How will CMS ensure the validity of improper payment estimates? The proposed and interim final rules permit the inclusion of statistical anomalies that may not be identified until after the Performance and Accountability Report is issued. Theoretically, it is possible for the PERM to be flawed by both dependent and independent variables. For example, a participant with an open Medicaid number determined ineligible through the PERM eligibility review could nevertheless have a second error cited if the sample claim was inappropriately denied. This situation could be produced by a variety of factors, and there appears to be no provision for un-duplicating error dollars.

➢ **Section III: Analysis and Response to Public Comments on the Proposed Rule**

1) The CMS response that the use of a Federal contractor significantly reduces State burden and costs seems to assume that the contractor will operate with minimal State technical assistance and that the eligibility review component will be no greater than the traditional MEQC effort. The New Jersey Medicaid Management Information System (NJMMIS) is a complex process with an imposing learning curve. The demand on State staff to educate the contractor staff is uncertain at best. Is enhanced Federal funding (90%) available for obligation? The eligibility review component is still under development; therefore, the demand on State resources cannot be estimated at this time.

2) The CMS response that it believes that, due to the minimal additional activity required by the regulation, participating States should not need to divert staff from other areas of program activities does not alleviate our concerns. Regarding the 10% cap on SCHIP administrative expenditures, we request that CMS consider exempting the cost of PERM-related SCHIP activities from the cap. We believe that PERM-related SCHIP activity costs should be 100% Title XXI funded.

3) The CMS response that denied claims are included in the PERM because of an OMB dictate (OMB guidance M-03-13, published 5/21/2003) does not resolve State

concerns. New Jersey's experience, gained through the Claims Processing Assessment System (formerly part of the MMIS Systems Performance Review), has shown that overpayments represent a different set of problems and should not be combined with either denied payments or underpayments. To include unspent dollars with misspent dollars attempts to change the definition of *error payment* and is certain to result in a meaningless statistic. New Jersey believes that two error rates should be developed -- one for overpayments and one for underpayments -- and that an appropriate gauge of misspent Medicaid dollars can only consist of overpayments.

4) The CMS response that the amount of the improper payment, if the claim was denied erroneously, would be the amount that should have been paid as a result of the review does not resolve State concerns. "Improper" and "error" are used interchangeably throughout the notice, perhaps inadvertently. Both terms indicate misspent funds and to count non-payments with payments is misleading. Overpayment, underpayment and denied payment errors should be calculated separately and reported separately.

5) The CMS response concerning claims/premium processing disputes between the State (its fiscal agent/vendor) and the provider/ participant indicates that dispute or outcome is immaterial to the PERM review (Page 58266, column 1). We strongly believe that unresolved disputed claims and/or providers under active criminal investigation should be excluded from the PERM process to avoid interfering with or compromising the resolution or investigation.

6) Review Procedures, Medical Reviews: The CMS response to most of the comments in this section that the use of a Federal contractor addresses the expressed concerns is questionable. Although States are not responsible for performing medical review, CMS has obligated States to provide whatever technical assistance is needed for the contractor to perform its duties.

7) Review Procedures, Eligibility:

   a) The CMS response to most of the comments in this section that the expressed concerns will be considered by its eligibility work group and addressed at a later date is acceptable, except for the comment regarding citing errors for participants sampled for one program (SCHIP) and found eligible for the other (Medicaid). We would agree that the entire payment represents a misspent expenditure if the participant were neither SCHIP nor Medicaid eligible. Otherwise, only the difference between the levels of Federal matching should be considered erroneous. Since the PERM process allows for adjustments to claims, adjustments to Federal claiming should also be allowed.

   b) The CMS response that the State should be accountable for all Medicaid eligibility determinations regardless of which State agency made the determination is acceptable. The same should apply to Federal agencies. SSI

claims are not exempted from the process-medical necessity reviews. However, SSI cases are exempted from the eligibility review; if not, States will have a great argument for recovering overpayments identified through the eligibility review.

c) The CMS response concerning sampled providers/participants identified as under active Medicaid Fraud Control Unit (MFCU) [or any known State program integrity/law enforcement unit] investigation needs revisiting. We would discourage interfering with the active investigations, especially those involving covert operations.

8) Appeals:

The CMS response concerning existing appeal procedures on the PERM process needs revisiting. PERM processing-medical review findings for disputed claims may be adjusted later based on the resolution of the dispute. The same option should apply to disputed eligibility reviews that result in fair hearings or grievances. Decisions that are reversed through the fair hearing or grievance process should be backed out of the error rate.

➢ **Section IV. Provisions of the Interim Final Rule**

a) Page 58272, column 2: "The contractor will select a number of States to be reviewed." Who selects the participating States, CMS or the Federal contractor?

b) Page 58273, column 2: CMS believes that it is not necessary to require States to submit new State plan material concerning PERM activities. Are States required to submit a plan amendment concerning PERM?

➢ **Section V. Collection of Information Requirements**

Regarding the accuracy of the CMS estimate of the information collection burden, it is inherently understated. A variety of State staff disciplines must be made available to the Federal contractor to provide expert technical assistance. How much is difficult to gauge because the contractor's capabilities are unknown. Also, without knowing the scope and magnitude of the eligibility review, it is difficult to perform a practical needs assessment. CMS acknowledges that, without the eligibility review component, it cannot state for certain what it will cost the States.

➢ **Section VI. Response to Comments**

No comment.

➢ **Section VII. Regulatory Impact Statement (Overall Impact)**

New Jersey anticipates that its actual cost for performing eligibility reviews similar to MEQC reviews will exceed the CMS' previous estimate of $570 per eligibility review. However, the CMS work group should consider this figure as a starting point when developing their eligibility review methodology. If there is a return on investment, it may not be possible to estimate without successive years of operation.

- **Subpart Q – Requirements for Estimating Improper Payments in Medicaid and SCHIP**

The following summarizes our main concerns, in response to the issues presented in the preamble section of the notice of interim final rulemaking.

1) Currently, the burden to participating States is unknown. It is anticipated that some of the claims information needed by the contractor will require system enhancements and the amount/extent of technical assistance to be given is uncertain. The eligibility review component, which we feel will be a challenge and costly, has yet to be developed.

2) The demand on State staff to educate the Federal contractor staff is expected to be greater than CMS estimates. We plan to claim enhanced Federal funding (90%) for this obligation, if allowed.

3) The inclusion of phantom dollars consisting of underpayments and denied payments as part of the error rate will bias it and raise serious questions over its value.

4) SSI claims should be excluded from sampling to avoid biased findings. Because New Jersey has a Section 1634 agreement, SSI recipients are determined Medicaid eligible by a Federal agency (SSA). Under CMS policy, New Jersey would be held accountable for payment errors in connection with the processing validation and/or medical review. However, experience has shown that, for whatever reason, SSA does not always close SSI cases timely. SSI recipients discovered to be deceased, incarcerated or out of the country when the service was given would nevertheless be deemed eligible by the PERM Eligibility Review. The policy of including SSI claims would bias the estimate, simply because Medicaid eligibility certifications by state agencies are considered in a different way than Medicaid certifications by SSA.

5) We strongly believe that unresolved disputed claims and/or providers under active criminal, civil or administrative investigation should be excluded from the PERM process to avoid interfering with or compromising the resolution or investigation.

Submitter : Dr. Don Hawley **Date:** 11/04/2005

Organization : HCF

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

Utah has been trying today to post a comment on this site with out success due to technical problems. As a result, our comments are late, But I hope you will accept them as the staff was finally able get the website to accept the attachments.

Submitter : Mr. Patrick Finnerty **Date:** 11/04/2005

Organization : Department of Medical Assistance Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

see attachment

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

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

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

Submitter : **Dr. Matthew Onstott** **Date: 11/04/2005**

Organization : **NM Human Services Department**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC-30-Attach-1.DOC

CMS-6026-IFC-30-Attach-2.DOC

New Mexico Human Services Department

Bill Richardson, Governor
Pamela S. Hyde, J.D.,

November 4, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC

RE: Comments on Payment Error Rate Measurement Interim Rule

The New Mexico Human Services Department is responsible for the State's Medicaid program. The Department has participated for the past two years in the Payment Accuracy Measurement (PAM) and Payment Error Rate Measurement (PERM) pilot projects. We appreciate the opportunity to submit the following comments regarding the Interim Rule.

The Department's comments can be grouped into three areas and are, for the most part, general comments not specific to particular sections of the Interim Rule. Many of our comments are really requests for further information, as the Rule did not provide sufficient detail for the Department to clearly assess its impact. We also wish to voice our concern for what we feel is prospective withholding that forces the state to relinquish federal funds before being able to adequately adjudicate claims that may have been paid incorrectly. Finally, we have comments specific to the issue of determining the accuracy of eligibility determination.

Comments regarding the CMS contractor and the proposed review process:

We have many questions surrounding the planned activities of the contracted entity that CMS intends to perform the review of claims. Our experience over the past two years in the PAM and PERM projects is that provider follow-up is essential to ensure an accurate assessment of payment accuracy. For example, our reviewers made many contacts with some providers in order to obtain the documentation necessary to demonstrate an accurately paid claim. We wonder about the ability of the contracted entity to perform the kind of follow-up that our staff conducted in PAM and PERM. We believe that the States must be able to have significant interaction with the CMS contractor in order to ensure the thoroughness and quality of their review process.

During the course of the PAM and PERM projects, we also found that reviewers were required to have a deep understanding of State-level policies and regulations in order to appropriately conduct reviews. We are concerned that a national contractor would not be well-situated to fully grasp the nuances of each individual state program without a very close working relationship with state staff.

Of course, this, along with the up-front processes of sampling and stratifying claims data, mean that States will necessarily expend a significant amount of resources in the PERM process. We have found our error rates to be quite low (0.14% in the past year). Given our relatively high FMAP, this means that State resources will be expended disproportionately to the return to the State.

We are also concerned that the Interim Rule does not address any kind of appeals process with the CMS contractor. We foresee instances where the State will disagree with a finding of the contractor. What will be the States' recourse in these instances?

States need to be better informed about the statistical methodology that will be employed to extrapolate from the sample to the universe. Will a 0.14% error rate be applied to the total expenditure of the State's Medicaid program? If so, will CMS seek recoupment at the universe level, rather than on specific claims found to have been paid inaccurately? This would pose significant problems to States' accounting systems, MMIS integrity, and State's budgets.

Comments regarding CMS recoupment based on contractor findings:

Our primary concern in this area is that the State will be asked to return federal funds without time for an adequate adjudication process. Again, we question what the appeal process will be with the CMS contractor. We are also concerned that the contractor may not be flexible in considering claims adjustments that occur outside of the 60-day window. We are also concerned that the State may be in the position of returning federal funds even when recoupment on claims proves impossible (e.g., when a provider has been terminated or cannot be located).

Comments regarding eligibility:

The State is concerned about the administrative burden placed not only on staff that need to pull claims data and work with the CMS contractor on medical and processing reviews, but also on staff currently conducting eligibility reviews. For PAM and PERM, the State was allowed to use the eligibility subsample as a substitute for its MEQC sample. If separate samples had to be used, thus significantly increasing reviewer workload, additional staff would be necessary to complete the work. We are hopeful that CMS will find a solution that both meets the IPIA requirements and does not place this undue burden on States. We are also interested in hearing how eligibility errors will translate into dollars. Due to both of these concerns, we look forward to hearing more about the workgroup proposed to examine eligibility issues.

New Mexico Human Services Department

Bill Richardson, Governor
Pamela S. Hyde, J.D.,

November 4, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-IFC

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Of course, this, along with the up-front processes of sampling and stratifying claims data, mean that States will necessarily expend a significant amount of resources in the PERM process. We have found our error rates to be quite low (0.14% in the past year). Given our relatively high FMAP, this means that State resources will be expended disproportionately to the return to the State.

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Submitter : **Ms. Diana Ducay** **Date: 11/05/2005**

Organization : **California Department of Health Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-6026-IFC-31-Attach-1.DOC

The 2004 MPES findings indicated that 96.43 percent of claims were billed and paid appropriately. California also participated in the Payment Accuracy Measurement (PAM) in 2004, using the PAM methodology the findings indicated that 98.4 percent of the claims were billed and paid appropriately. The MPES exceeds the requirements of the (PAM) as well as the Payment Error Rate Measurement study (PERM), and California believes the MPES results are more accurate and reliable. When conducting both the MPES and PAM in 2004, California took great care in explaining the differences between the two studies to avoid confusion. When selected for PERM, California will again have to take the time to explain the differences between the two studies to avoid confusion. For California, the PERM study will be duplicative and cursory.

Page 58262 Section - Analysis and Response to Public Comments on the Propose Rule:

CMS:
"The new approach to error rate measurement will rely on a Federal contractor to conduct medical and data processing reviews and produce State-specific and national Medicaid and SCHIP error rates."

Comment:
California has a concern regarding CMS' plan hire two separate contractors to conduct the medical and data processing reviews. The use of two contractors is problematic, in that the state will need to work with, and respond to, requests for information from two separate entities. Each contractor will make their own separate requests which will require time and effort and will likely result in a duplication of work. Staff will have to be redirected from their assigned duties and spend time responding to requests from the Federal contractors in addition to responding to questions from our own contractors and providers.

Page 58623 Section – Purpose and Basis

CMS:
"Only those States selected for review each year will be required to provide information necessary for claims sample selections and reviews, will provide technical assistance as needed, and will implement and report on the corrective actions to reduce the error rate."

Comments:
For a state like California, with a large and complex Medicaid program, to provide the Federal contractor with information necessary for claims sample selections and reviews and to provide technical assistance for the contractor will require significant staff time. We believe it will very difficult for a contractor who is not familiar with the claims processing systems and policies of the California Medi-Cal program to conduct a study without extensive interaction and technical assistance from both the State staff and our Fiscal Intermediary, Electronic Data Systems (EDS). Since the PERM is a requirement for Federal agencies to measure the accuracy of federal payments, all costs incurred by the States in the project should be 100% reimbursed by the Federal government.

Page 58623 Section – Purpose and Basis

CMS:

"The Federal contractor's responsibility for medical and data processing reviews should lift a substantial portion of the burden from the States."

Comment:
California disagrees. The Federal contractor will be paid by a claim and have little incentive or no incentive to pursue providers for documentation and additional information. In addition, because California's Medi-Cal program is large and complex we are very concerned the contractor will not accurately review the claims. Because California will be held accountable for the findings of the contractor from both a fiscal and corrective action standpoint we will need to review each and every error to ensure accuracy, this is a significant workload on the state.

Page 58263 Section - Purpose and Basis

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

Comment:
We disagree. In addition to the concerns stated above, the States will be required to notify providers of improper payments identified by the federal contractor. Policies and Procedures will have to be developed to address how notifications to providers will be handled. California is a large state with a large and diverse provider population. The time and expense that California will have to incur will be costly. Staff will have to be re-directed from their assigned duties to the process of notifying providers and collecting overpayments. Technical assistance to providers must be also offered to the providers in order to explain the PERM study and it's findings which includes the recovery of payments. Further, CMS will also be requiring the States to submit their policies and procedures on a quarterly basis. California is a large state that has a rapidly changing demographic population. California is constantly updating our procedures to reflect the needs of our citizens. This is an extremely complex responsibility. We would be required to divert staff from this responsibility to the task of meeting the Federal mandate for the submission of policies and procedures quarterly.

Page 58264, A. Purpose and Basis

CMS:
"Since we are engaging a Federal contractor rather than the States to produce error rates, the recommendation to form to convene a taskforce to track State's progress on medical and data processing reviews no longer applies."

Comment:
California believes that there is a need for an advisory group organized to provide feedback to CMS on how the error rate study could be improved. The advisory group could provide feedback from providers on how to improve the error rate study.

Page 58264 Section - Claims Universe and Sampling a. Denied Claims

CMS:

"The IPIA defines improper payment as any payment that should not have been made in an incorrect amount including overpayments and underpayments. OMB guidance
M-03-13, states that incorrect amounts are overpayments including inappropriate denials or payment of service."

Comment:
We do not agree that denied claims should be included in the PERM. Denied claims do not fit the definition provided by CMS. A denied claim does not result in any kind of payment, under or over, from federal funds to a provider. The proposed regulation indicated that the sample would consist of claims for which federal funds were paid for services furnished. Federal funds are clearly not used to pay denied claims.

Page 58265 Section - Medicare Claims and Other Premium Payments:

CMS:
"The proposed rule intended to include Medicare crossover claims in the review since these are considered part of the universe of claims. The universe includes all claims submitted by providers, insurers, and managed care organizations for which a decision to pay or deny was made by Medicaid or SCHIP. Under this interim final rule, these claims (Medicare Crossover) would be included in the universe and subject to sampling and review to the same extent as any other claim.

Comment:
Medicare crossover claims should be excluded from the PERM. The States do not determine eligibility or review Medicare claims for medical necessity. It is unfair to hold the States accountable for an area over which it has no authority.

Page 58271 - Recoveries:

CMS:
"The requirement to return the Federal share of erroneous payments within 60 days of identification is in statute and regulation and does not allow for only cost effective recoveries."

Comments:
California does not agree with the interpretation that the claims identified in the PERM must be considered erroneous payments requiring collection under the 60 day rule. There is no indication in the responses from CMS that the providers or the States will be afforded an exit conference normally provided prior to collection of an overpayment.

While there is a discussion of an appeal process, the process discussed is the normal appeal process used by providers for audit disputes. States should be permitted to review and dispute the findings of the federal contractor. There are likely to be occasions where medical consultants employed by the State and the Federal contractor will disagree over study findings. There should be a dispute process in place where the medical professionals employed by States are able to examine and dispute medical review findings.

Further, the PERM is a very different process than an audit and the likelihood that a provider will incur the expense of an appeal on a claim that could amount to only a few dollars is not likely. The state will then be faced with the expense of pursuing collection of a small dollar amount and the inclusion the claim in the error computation. Should a provider decide to appeal, CMS expects the state to incur the expense of the appeals process. The appeal system in California is already overburdened with existing cases with overpayments far in excess of the PERM claims. This is clearly not a cost effective use of state time and resources.

We also have the following questions:

- There will be the likelihood that the State has already discovered the overpayment and collected the reimbursement. How would the Federal contractor address this possibility?
- If the provider appeals, will the payment be delayed pending the outcome of the appeal and will the computation of the error rate also be pended?
- There will be a likelihood that the PERM will select a claim that California is already auditing. How would such a claim be handled?

Although CMS believes that the 60 day rule regarding the recovery of erroneous payments is required by statute, there should be a process in which CMS should make exceptions in the PERM process. It is recommended that CMS consider requiring states to complete audits of all providers that had erroneous payments identified in the PERM and that the federal portion of overpayments identified as a result of the audits be returned within 60 days. This would meet the spirit of the 60 day rule and have a likelihood of producing a result more cost effective for both the state and CMS.

Page 58272 Section – Appeals:

CMS:
Appeals procedures are not modified by this rule and therefore have not been addressed.

Comment:
California disagrees because appeals will have a significant impact on the PERM results. Providers have the right to appeal orders for recovery of overpayments and have a hearing before an Administrative Law Judge. The appeals process may take years for adjudication and expenses will incurred by the State. CMS has not addressed the expense of including PERM claims in the States' existing appeals process or how the claims that are in appeal will be handled when computing the error rate. As stated above it is not cost effective or reasonable for CMS to require the States to absorb the cost of appeals for single claim items.

Page 58274 Section - Regulatory Impact Statement

CMS:
"Since we have not determined the type of eligibility review that will be done to gather eligibility rates under IPIA, we cannot state for certain what State and Federal costs will added to the $22.3 million Federal amount."

Comment:
CMS' uncertainty over the costs that States may be required to pay to support the eligibility reviews are of concern. The uncertainty of the costs the States will required to incur may lead to unknown and unplanned for costs that States may not have budgeted.
In this era of tight budgets, every dollar spent is subject to great scrutiny.

Page 58274 Section - Regulatory Impact Statement

CMS:
"A request for medical documentation to substantiate a claims payment is not a burden to individual providers nor is the request outside the customary and usual business practice of a Medicaid and/or SCHIP provider."

Comment:
Any time providers are required to redirect their staff to photocopy medical records and submit the record for review, there is a cost to the provider. Providers with small office staff will have to re-direct staff from their routine duties to photocopying records. Medical records may be stored offsite which may add to the time and costs of retrieval. Providers will view the time and effort spent retrieving and photocopying documents as being significant. These concerns cannot be dismissed. Providers in California will also be required to provide documentation for the California MPES and the PERM study. Providers will also have to incur the expense of appealing and defending a single claim. All of these requirements add costs to the provider.

PART II

This section provides the California Managed Risk Medical Insurance Board's ("Board") comments pertaining to SCHIP/Healthy Families Program (HFP) issues.
The Managed Risk Medical Insurance Board manages the major part of California's SCHIP though its Healthy Families Program, using an insurance based, managed care model in which capitation payments are made to contracted health, dental and vision plans. The Healthy Families Program includes two "carve outs" (for mental health services to children with severe emotional disturbances through the counties, and for children with severe long term health conditions through the California Children's Services Program). The HFP also includes a "bridge" program from Medicaid Medi-Cal in California) to SCHIP and presumptive eligibility paid through the Child Health and Disability Prevention Program Gateway. All of these use SCHIP funding. The "carve outs" and "bridge" are paid by the Department of Health Services (DHS) through a combination of fee for service and managed care capitation and the Gateway is paid by DHS through fee for service.

The Federal Register Summary and proposed regulations are unclear and inconsistent on what is intended to be covered through these regulations The Summary (Page 58260) states that SCHIP fee for service and managed care payments will be addressed at a later time. However, in the proposed regulations there are references to SCHIP payments. Furthermore the regulations establish a standard for payment error correction in fee for service payments that, if carried over to managed care payments, would give insufficient time for payment reconciliation.
Because the summary and the text of the regulations, taken together, are unclear concerning what is proposed in the SCHIP arena – and particularly concerning what is proposed for SCHIP managed

care payments – SCHIP programs do not have sufficient information to comment adequately on the impact and burden of these proposals. We hope and expect that any proposed data collection, reporting and recoupment activities concerning SCHIP will be the subject of a subsequent proposed regulation, on which SCHIP programs will be able to comment more meaningfully. We look forward to the establishment of the work group on Medicaid and SCHIP eligibility and hope to participate in that group. However, since payment errors for managed care capitation are inextricably linked to eligibility, we want to ensure that the work group has been given the full opportunity to complete its recommendations before any regulations on either managed care payment errors or eligibility errors are made final.

Our specific concerns about the current interim regulation are as follows:

Page 58276 Section - Definitions and Use of Terms:

CMS:
"Payment means any payment to a provider, insurer, or managed care organization for a Medicaid or SCHIP recipient for which there is Medicaid or SCHIP Federal financial participation."

Comment:
Under this definition, SCHIP capitation payments to managed care organizations and insurers would be included, although it is the stated intent of CMS, on page 58260 of the Summary, that such payments be dealt with in the future.

Page 58276 Section – Information Submission Requirements:

CMS:
"States must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and SCHIP, that include but are not limited to-

a) Claims data and annual expenditures from previous year;
b) Quarterly, stratified adjudicated claims data from the review year;
c) All medical and other policies in effect and quarterly updates as needed to perform claims reviews
d) Data processing systems manuals;
e) Current provider contact information that is verified and/or updated to contain current provider contact information;
f) Repricing information for claims that are determined to be improperly paid;
g) Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining error rates in Medicaid and SCHIP, and
h) A corrective action report as prescribed by the Secretary for purposes of reducing the payment error rate."

Comment:
The required information listed in Section 431.970 appears to be specific to fee for service programs, but this intent is clouded by the imprecise definition of payment discussed above. The required information is not appropriate for estimating improper payments and determining error rates for the Board-administered SCHIP program using a private insurance/managed care model. The interim

regulations do not make clear when, how and to what extent these requirements would be applied to SCHIP programs that are based on private insurance and managed care.

Page 58276 Section – Recoveries:

CMS:
"States must return to CMS the Federal share of overpayments identified within 60 days in accordance with section 1903(d)(2) of the Act and related regulations at part 433, subpart F of this chapter..."

Comment:
This section appears to be applicable only to fee for service payments in Medicaid. Again it is unclear what CMS intends to do with recoveries of SCHIP overpayments. However it can be inferred from the CMS Response to Comments on the Recovery section (Page 58271), that CMS intends to impose the 60 day recovery requirement already in existence for Medicaid fee for service payments on all SCHIP payments, including capitation payments for managed care.

The proposed 60 day timeframe is arbitrary and unreasonable. States need a longer timeframe to reconcile and adjust payments before they are classified as errors (i.e., overpayments and underpayments). Specifically for California's SCHIP program, a reconciliation process is in place that makes positive and negative adjustments to capitation payments to health plans on a retroactive basis. The reconciliation process takes longer than 60 days. The Board suggests that CMS extend the 60 day timeframe to a minimum of 4 months.

Page 58276 Section – Strategic Planning, Reporting , and Evaluation:

CMS:
"A State plan must include an assurance that the State collects data, maintains records, and furnishes reports to the Secretary, at the times and in the standardized format the Secretary may require to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI. This includes collection of data and reporting as required under Section 431.970 of this chapter."

Comment:
It is unclear what CMS' intention is in cross-referencing the data collection and reporting requirements under Section 431.970 since the purpose and stated intention of the proposed regulations is to address Medicaid fee for service programs and since the cross-referenced data elements are inappropriate to SCHIP programs that are based on private insurance and managed care.