Submitter : jennifer lange **Date:** 10/24/2005

Organization : Department of Children and Families

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attached

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

Comments from Florida's Department of Children and Families
Federal Register volume 70, number 192 published October 5, 2005
Interim Final Rule
Medicaid Program and State Children's Health Insurance Program (SCHIP)
Payment Error Rate Measurement

No objection to the plan to address improper payments attributed to eligibility determination at a later date, or to using contractors to conduct the evaluation.

Support the concept of a workgroup to consider the best approach to eligibility reviews under the IPIA (Improper Payments Information Act of 2002).

Concern expressed about the lack of an administrative period to allow for report of changes in beneficiary status. Measuring eligibility solely on the date of service is inconsistent with policy at 42CFR 431.211 which provides 10 day notice prior to ending Medicaid eligibility for an individual. It is also inconsistent with quality control policies in other programs.

Concern expressed for conducting the Medicaid and SCHIP reviews independently. Recommend that this issue be considered by the workgroup that is convened to consider the best approach to measuring improper payments. In Florida, and presumably in other states, families applying for SCHIP are first reviewed to determine if they are Medicaid eligible. If they are eligible for Medicaid, they do not have the choice to be enrolled in SCHIP. Because the income limits are higher in SCHIP than Medicaid, it is not uncommon for children to lose Medicaid eligibility, while still meeting the criteria for SCHIP. Pursuing repayment of Medicaid overpayments in this situation seems counterproductive, especially for families who applied using only an SCHIP application. Further for purposes of estimating improper Medicaid and SCHIP payments, it would seem reasonable to offset overpayments in one program with underpayments in the other.

CMS-6026-IFC-2 **Medicaid Program and State Children's Health Insurance Program (SCHIP): Payment Error Rate Measurement**

Submitter : **Dr. Wendy Matos-Negron** **Date & Time:** **10/26/2005**

Organization : **Commonwealth of Puerto Rico Medicaid Program**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

The Commonwealth would not object to having the same rules apply to Puerto Rico if the Commonwealth had the same access to technology funding as the states do for their Medicaid programs. The lack of access to technology support puts financial strain on the Commonwealth and is a poor fiscal decision by the Federal government. Puerto Rico would encourage the Department to first seek support for PR have comparable access to technology funding so that PR is in a stronger position to meet error rate requirements. However, requiring PR to meet error rate standards without comparable access to technology support is a serious challenge. So far, unfunded mandates represent to the Commonwealth of Puerto Rico potential issues that evolve into legal actions and fiscal consequences to the territory government.

Submitter : **Ms. Stephanie Beck** **Date: 11/03/2005**

Organization : **Office of Vermont Health Access**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

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

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2086
www.ovha.state.vt.us

[Phone] 802-879-5900

Agency of Human Services

November 3, 2005

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

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

We would like to emphasize that:

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

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

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

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

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

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

PERM imposes a significant burden on the State of Vermont:

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

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

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

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

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

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

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

Sincerely,

Joshua Slen
Director

Submitter : **Susan Becktold** **Date: 11/03/2005**

Organization : **Oregon Department of Human Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC-4-Attach-1.DOC

Oregon
Theodore R. Kulongoski, Governor

Department of Human Services
Children, Adults & Families
Quality Control Unit
PO Box 14070
Salem, OR 97309
503-378-6826
Fax 503-378-8645
TTY 503-945-5896

November 3, 2005

Department of Health and Human Services
Centers for Medicare and Medicaid
RE: CMS-6026-IPC

Listed below are Oregon's Comments on PERM Regulations:

1. The burden estimate to States is not realistic. The amount of State time and resources that these reviews will require has been underestimated. Many States that have been participating in pilot PERM processes strongly state that a higher estimate is necessary.

2. Recommend that there be one main contractor; currently, there are 3. Concerns include: 1) Contractors will need to learn States policies, as well as their waivers; this would mean we would have to educate each one of them. 2) The potential issues from separate contractors not sharing data and communicating effectively to complete the reviews.

3. Request advance notification of the list of claims pulled for review. This will allow the States to begin to work with the providers. Advance notice would also be helpful if a provider that is under fraud investigation is on the list. Although there is discussion about whether or not those claims should be dropped from the review, this could skew the results if we always dropped these types of claims.

4. Clarification is needed on the State's appeal rights. If the provider is required to file the appeal and it is a low amount, they may not feel it is worth an appeal, but the error affects our error rate.

5. Clarification is needed on how the contractor will handle the non-receipt of documentation (from providers). Will this be considered an error? What attempts will the contractor make to get the necessary documentation for the claim? Will States have to intervene?

6. Will States have enough information to know that the error was appropriate or not (or will we receive a report with error codes)? States will need more information if CMS expects corrective action. In addition, rules do not include provisions to allow States to validate the contractor's findings.

7. Eligibility workgroup has already been formed, yet there has been no information sent to States on this, nor an opportunity for States to participate in the workgroup. In addition, States included in the workgroup (ie, New Jersey) have not participated in previous PERM pilots. Will there be an opportunity for States to submit their comments to the workgroup regarding the eligibility part of

the reviews?

Please contact Susan Becktold at the number listed below if you have any questions.

Thank you,

Susan Becktold, Manager
Quality Control Unit
Oregon Department of Human Services
503-378-6826 x 513

Submitter :

Date: 11/03/2005

Organization :

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-6026-IFC-5-Attach-1.DOC

North Carolina
Department of Health and Human Services
Division of Medical Assistance
Program Integrity
2501 Mail Service Center • Raleigh, N.C. 27699-2501
Telephone: 919-647-8000 • Fax: 919-715-7706

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary
for Health Policy and Medical Assistance
Carleen Massey, Interim Assistant Director

November 3, 2005

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

ATTENTION: CMS – 6026-IFC

Re: North Carolina's Comments: Payment Error Rate Measurement (PERM) in Medicaid and SCHIP
File Code CMS–6026-IFC

Dear Sirs,

North Carolina respectfully submits the following comments and questions regarding the Interim notice in the October 5, 2005, *Federal Register* which sets forth the State requirements to provide information to the National Centers for Medicare and Medicaid Services ("CMS") for purposes of estimating improper payments in the Medicaid and the State Children's Health Insurance Programs. To carry out this work, CMS proposes to engage multiple contractors to produce Medicaid and SCHIP error rates for selected states under the Improper Payments Information Act of 2002. Even if CMS employs outside contractors, we believe the proposed Payment Error Rate Measurement (PERM) or Medicaid Error Rate (MER) interim regulations will fall short of their intended goal and create a duplicative, expensive and unfunded bureaucratic burden for states.

As we have stated previously, CMS details on the role of states in PERM-MER lack clarity and consistency. For example, in the Federal Register, notice the listing of state responsibilities is different than the listing of state responsibilities sent to State Health Officials by letter on 10/6/05. In the Federal Register the notice minimizes the role of states when addressing the burden issue. Yet the State Health Officials letter expands the listing of support activities with more open ended tasks that will be required of the states. Failure to address state responsibilities for assessing recipient eligibility and managed care claims in the notice are further indications of the incomplete nature of the proposed regulations.

As requested, our other comments, which are broken down by Federal Register heading, are as follows:

"I. Background" Section

- Supporting references to proposed state error rate methodology and the weighted aggregation of multiple state rates into a national error rate have not been documented by CMS in this notice beyond a passing reference in this section. We understand from current PERM participants that the Lewin spreadsheet methodology for calculating state error rates has been revised multiple times this year due to errors or other changes. Before any PERM-MER final regulations are

adopted, CMS-Lewin should be required to publish any and all related statistical formulas and methodologies for state error rate calculations review by the states.

"II Provisions of the Proposed Rule" Section

- This interim rule is incomplete in that it does not addressing either eligibility or managed care claims reviews. CMS should refrain from publishing any final rule under PERM-MER until such time as CMS can draft the review process, relative to these areas for the states to review. CMS should open workgroup participation on SCHIP, eligibility or managed care to any state having an interest. Workgroup minutes should be circulated to all parties.

- We understand that CMS has already convened study groups on eligibility reviews and managed care. CMS should share the options under consideration with the states. If the states are ultimately going to perform these tasks and reviews, then the burden on states would be far higher than what has been estimated by this notice. Alternatively if a contractor is going to conduct MER eligibility reviews, then this approach would also require more extensive fieldwork, correspondence and support from the state. There are also confidentiality issues both in state law and federal law concerning Social Security Administration and Internal Revenue Service information in the case records.

"III Analysis and Response to Public Comments on the Proposed Rule" Section

- Since states will have to research policies to respond to clinical or operational questions from any of the multiple contractors, CMS should recognize that staff time (program integrity, clinical policy, fiscal, IT, etc.) will have to be diverted from their existing duties (fraud investigations, policy formulization often in response to legislative initiatives to reduce Medicaid costs, etc.). For example, the PI and MEQC staffs in NC target known areas of vulnerability. Diversion of staff time could result in a decline in recoupments or fewer ineligible recipients being detected with fewer corrective actions implemented, which could lead to unnecessary Medicaid expenditures.

- Another burden to the states involves the amount of information that must be gathered and reviewed in context for an adequate error determination of an improper payment. Contract medical reviewers need access to recipient case histories and provider claim patterns over a number of years to make a full and complete assessment of claims. Contextual reviews of a recipient's claim history is necessary to access medical history or to indicate which provider medical records will need to be reviewed. NC will make available onsite access to the contract medical reviewers if requested.

- NC providers historically are very guarded about the confidentiality of their files and can be expected to provide a challenging environment to any contractor requesting those records. Will the contractor cite CMS or the state's authority when requesting medical records? How will a contractor handle the HIPAA complaints; many of which will be directed to state Medicaid staff?

- State programs routinely make repeated attempts to obtain the appropriate documentation from providers. Will the national medical review contractors have equal diligence in obtaining records? How persistent and thorough will the contractor be at locating the site where the claim's medical record is stored? What incentive will CMS offer to contractors to ensure both diligence and accuracy? Will the national contractor impose a fixed response deadline on the provider (PERM Year 4)? Labeling a claim an error after the provider exceeds an arbitrarily imposed response deadline does not make a payment improper.

- Contrary to the notice's assertion that ongoing provider investigations are not a "relevant issue", we believe that ongoing investigations are highly relevant. National contractor interactions with a suspect provider have the potential for alerting a fraudulent provider to an investigation. After a review of selected providers in the sample, states could alert the national contractor to substitute a different claim for review. Our state Medicaid Investigation Unit (MIU) has over 175 cases under current investigation and Program Integrity is investigating another 1,000 providers. Confidentiality is a requirement of our contract with the MIU.

- A critical omission is that there is no provision for state staff to re-review the audit findings or rebut initial error determinations by the national contractor. Reconciling eighteen different state Medicaid program's policies and

procedures without error verification will raise doubts about the accuracy of any findings. States should be given the opportunity to review and verify findings before any error rate is published for a state.

- Another potential burden to states in the notice is the requirements that states handle provider appeals. If CMS follows the national contractor model, then national contractor should be responsible for defending their decisions related to all provider appeals before the Hearing Office in NC. States should not have to expend time and effort to defend the error findings of a national contractor when state staff did not participated in the reviews.

"IV Provisions of the Interim Final Rule" Section

- Use of multiple contractors as outlined in this notice is an untested, needlessly complicated approach to IPIA and a very real coordination burden to the states. CMS and OMB should consolidate work for one lead contractor with the other two as subcontractors. By using three contractors, CMS and OMB have placed an additional and unreasonable burden on states to ensure timely and coordinated responses to contractor questions, requests, etc.

- The proposed random selection of states to participate in PERM on a once in three years cycle will make it exceedingly difficult to predict what resources a given state will need to carry out this national contractor model of PERM. As a consequence, there will be time delays while state resources are identified to support the national contractors. If state support is not forth coming, states will be improperly blamed for not meeting CMS deadlines. Even temporary positions are time consuming to establish at the state level. Retention of knowledgeable and experienced staff for the PERM project will not be possible on a once every three year cycle.

- We again ask does a "one size fits all" statistical approach work across fifty different state Medicaid programs?" This is an especially important question to pose in light of the differences between states with managed care populations and the notice's admission that CMS-OMB have not yet determined the best method to measure improper payments for Medicaid and SCHIP recipients.

- Another concern is the state-specific error rate. We believe that deriving state-specific error rates goes beyond the requirements of the Improper Payments Act of 2002 (IPIA). The fact that state-specific error rates will be derived and then extrapolated to determine a national rate makes it much more important that states have some ability to contest the validity of their respective error rates. Are error rates in a state with a high managed care population equivalent to a state with predominately fee for service? How can CMS-Lewin assert that any error rate calculation in the first year is complete without managed care claim reviews and/or eligibility reviews?

"V. Collection of Information Requirements" Section

- We have noted previously that the "Improper Payments Information Act of 2002" did not require state-level error rates and we again question CMS's decision to adopt a state-level error rate measurement system. North Carolina has been measuring improper payments since 1997 in conjunction with our State Auditor with fewer staff and far less expense than what CMS proposes in their PERM process. Our state's MEQC program also currently determines the Medicaid eligibility payment error rate and corrective actions. CMS has not provided any response on how these ongoing activities would not create duplication to this state and other states.

- Does CMS propose that PERM-MER selected states establish data use agreements with each of the three national contractors?

- CMS needs to adopt specific procedures addressing how fraudulent claims and providers under active state investigation will be handled. National contractor should have to provide the states with a listing of sampled providers to compare with known investigations. Lewin could over sample strata on a quarterly basis to allow for claim replacements.

- Annual and quarterly downloads of Medicaid Management Information System (MMIS) files, will require formal change requests to the fiscal agent. To comply with minimum data sets, states will have to pay their fiscal agents for any and all work that amends the fiscal agent's scope of work. A contractor will also need substantially more data files from the states than specified in the notice which will increase the burden to states. In addition to adjudicated claims data and

medical policies, there are a number of dynamic reference files/subsystems in state systems including but not limited to Eligibility, TPL, Prior Authorization, Utilization History, Processing Edits, and Pricing files that are essential for auditing claims. Additional information from CMS-Lewin will be necessary on the stratification of claims, with examples, to ensure proper inclusion of quarterly claim updates.

Data processing system manuals will be an additional cost to states. Existing IT staff is currently coping with the transition to a new fiscal agent and may not have the extra time to interpret fields for a national contractor's process reviews or provide answers in a timely fashion.

- "Current provider contact information" is most likely the billing address of the provider which is not always the same as the mailing address where recipient medical records are stored. Does CMS intend for states to track down the recipient's medical records (from single or multiple providers) and then provide this information to the national contractor? How will the states know which medical records (from single or from multiple recipient providers) will be needed for review by the national contractor?

- Re-pricing of claims determined by the national contractor to be improperly paid will require the national contractor to copy all medical records associated with the claim review and to provide them to the states. Note that providers in NC have a year to submit valid claims and eighteen months to adjust their claims. Can states factor in both provider and DMA adjustments in the re-pricing of claims? How will interpretations be resolved between the national contract reviewer and the states?

- Previous projections of the cost burden to states were underestimated. Current revised estimates of 1,630 staff hours and $620,000 per year are still low, minimal figures. We again challenge whether the full cost, time and effort impact on states have been accurately assessed. From other vendor contracts, states are well aware that substantial staff time is required to support initial contractor start-up and follow-up with contractors on state policies and to stay in continuous communication with them on a variety of day-to-day issues. This would be especially true for any contractor unfamiliar with the state's Medicaid rules and regulations. If CMS and OMB truly support their estimates, then CMS should provide 100% reimbursement to states for any staff time and expense necessary to comply with forthcoming CMS PERM-MER regulations.

- CMS should elaborate on what the Secretary will require of states in their corrective action reports. For example, if a provider miscodes a claim or fails to adequately document a service in their medical records, what is the appropriate corrective action expected by CMS beyond education of that provider's staff? Will corrective actions be required for all errors or at what percentage point or dollar threshold will corrective actions be required? Will states have the option to disavow or appeal any national contractor findings to which they object?

"VII. Regulatory Impact Statement" Section

- The 10/5/05 notice's Regulatory Impact Statements and associated cost estimates are based on incomplete data, excluding time and effort for either eligibility or managed care claim reviews. All PAM-PERM funding was based on fixed price agreements with maximum funding levels. CMS should be required to provide full funding for its national contractors model. CMS should require all eighteen initial FFS states to track all attendant cost for staff time and effort in FFY 06. Final PERM regulations should not be issued until a more realistic cost baseline can be ascertained and a revised regulatory impact assessment performed.

- CMS rationale that states will be limited to producing only "information on hand" is disingenuous. States will incur new, additional, undocumented cost to fulfill PERM-MER requirements. At a minimum CMS should ask each state to track all manpower, direct and indirect costs associated with the FFS reviews.

We are hopeful that CMS will carefully analyze these reservations and questions before issuing any final regulations. A summary of our recommendations are as follows:

1. We suggest that CMS delay issuing any final PERM-MER regulations until it can put forward a complete set of regulations that addresses eligibility, managed care claims review, realistic cost assessments of the burdens to states of the untested national contractor model, and the other issues.

2. We suggest that CMS submit the final statistical methodology for calculating individual state error rates, the propose methodology for weighted aggregation of individual state rates and the medical review protocols to be used by contractors when reviewing state claims to the states for their review and comments.
3. We suggest that CMS restructure vendor contracts to reward accuracy, persistence and thoroughness of claim reviews. States should be able to verify the contractor's findings on any error determinations.
4. We suggest that CMS instruct the statistical contractor to over sample stratified claims and permit states to substitute claims when a state or MIU investigation is already in progress for a sampled provider.
5. We suggest that CMS reimburse the states for 100% of direct and indirect cost associated with PERM-MER.
6. We suggest that CMS employ an independent contractor to evaluate the final results, accuracy and cost effectiveness of the PERM-MER process.

As in other Medicaid initiatives, we are continuously concerned with assuring the integrity of the Medicaid program. However, we want to ensure that our limited state resources are directed toward this goal in the most cost-effective and productive manner. Thank you for considering our comments. If you have any questions, please do not hesitate to contact Carleen Massey or Chuck Brownfield at 919-647-8000.

Sincerely,

Carleen Massey
Interim Assistant Director

Mark T. Benton
Senior Deputy Director and COO

cc: L. Allen Dobson, Jr., MD
Nancy Henley, MD

Submitter : Mr. Jerry Friedman **Date:** 11/03/2005

Organization : American Public Human Services Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-6026-IFC-6-Attach-1.DOC

APHSA
American Public Human Services Association

November 4, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop: C4-26-05
Baltimore, MD 21244-1850

Attention: CMS-6026-IFC

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

Dear Dr. McClellan:

The American Public Human Services Association (APHSA) and its affiliates, the National Association of State Medicaid Directors and the National Association for Program Information and Performance Measurement, respectfully submit this comment letter on Medicaid and SCHIP Payment Error Rate Measurement. APHSA 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). APHSA submitted comments on August 15, 2005, and again on September 26, 2005, in response to information collection notices describing CMS' proposals to retain a federal contractor to conduct the medical and systems review components of PERM. As noted in this interim rule's preamble and in this year's two previous information collection notices, CMS' proposal to retain federal contractors to produce state-specific Medicaid and SCHIP error rates arose from public comments CMS received in response to the PERM proposed rule published on August 27, 2004, "Medicaid Program and SCHIP Payment Error Rate Measurement" (69 *FR* 52620).

APHSA submitted comments on the August 2004 PERM proposed rule. In our comments, APHSA criticized the overall PERM proposal as one that would be costly and challenging to implement and that could yield invalid results. We also noted that the Improper Payments Information Act of 2002 (IPIA) did not specifically require state-level error rates, and therefore we questioned the need to implement a PERM process to produce state-level error rates.

APHSA and others suggested CMS retain a federal contractor to conduct the nationwide PERM assessment. As we noted in our comment letter dated August 15, 2005 (CMS-10166), on CMS' notice of proposed information collection, we appreciate CMS' decision to accept the recommendations of commenters and retain a federal contractor for Medicaid and SCHIP PERM.

However, although APHSA generally supports the federal contractor approach for Medicaid and SCHIP PERM, we have some concerns with some components of CMS' implementation plans including:

- transparency and participation in the rule making process, particularly for development of the eligibility and managed care components of PERM;
- requirements on states that exceed those described in the interim rule;
- 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' workplans, work statements, and protocols.

As APHSA indicated in our August 15, 2005 comments, we believe that CMS' July 22 and August 26, 2005 announcements contain inadequate information to evaluate fully their impact on states and soundness.

State Burden

- States selected for PERM review will be required to submit to the federal contractor annual Medicaid and/or SCHIP expenditures and quarterly stratified claims data. In the first information collection proposal, it was unclear that states would be required to submit quarterly stratified claims data. Although APHSA appreciates the clarification that states will be required to submit stratified data, this is an additional burden. Stratification of quarterly claims data by individual states could also result in errors and inconsistencies between state PERM estimates. APHSA encourages CMS to have the federal contractor conduct the quarterly claims stratification to ensure consistency across states and from quarter to quarter.

- APHSA encourages CMS 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. We suggest that CMS establish a steering committee or other advisory group that includes state representatives to help ensure that the PERM contractors consider all the logistical issues and address potential data collection issues before beginning their onsite and interactive work with states in collecting medical review policies, manuals, and system documentation. For states with fiscal agents, obtaining systems documentation is likely to require assistance from fiscal agent staff, which may involve contracting changes or unanticipated additional support expenses. If state representatives have the opportunity to participate through an advisory or other steering committee, states might be able to assist in reducing the "steep learning curve" facing federal PERM contractors and also reduce demands on state staff to support the PERM contractors.

- We question whether full administrative cost burdens of these proposals have been incorporated into the announcement. We note that CMS nearly doubled states' burden hours estimates from the July (830 hours) to the August 2005 (1,630 hours) information collection notices, but these estimates are still insufficient, particularly during the startup of a complicated program with many variables and state-to-state variation. States with prior PAM

Pilot experience report that substantial staff time (the equivalent of at least a half-time position) 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 we suggested in our August 15 comments and reiterated in our September 26 comments on the proposed information collection initiative, 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. It seems likely that 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. We encourage CMS to consider additional support to states during this startup phase to ensure that the process is workable and that both states and CMS are satisfied that the resulting error rates are valid, consistent, fair, and accurate. Neither CMS nor states will be well served by PERM results that are based on incomplete data, a flawed methodology, or inconsistent application. CMS could avoid considerable criticism by ensuring that states have the resources to adequately support the PERM contractors during the all-important first round.

- As we noted in our comments submitted on August 15, and September 26, 2005, on the information collection proposals, we reiterate our objection to inclusion of denied claims in the sample universe. The proposed regulations 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, and therefore we believe that denied claims should be removed from the sampling universe.

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

- In addition, the federal contractor will likely need more information from the states than specified in the interim rule. To review and assess payment error accuracy, contractors will need adjudicated claims data and medical policies, as well as a number of dynamic reference files/subsystems in state 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.

  More importantly, APHSA believes 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.

We encourage 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.

- It is unclear from either the Preamble or the interim rule whether there will be a separate systems review component in the process. We ask that CMS further clarify the extent to which systems will be reviewed as part of PERM.

- Finally, providers historically are very guarded about the confidentiality of their files, and can be expected to provide a challenging environment to contractors requesting records. Many state programs routinely request records multiple times and still must resort to creative tactics, such as having fiscal intermediaries assist in getting complete records. APHSA encourages CMS to implement incentives in PERM contractor's statements of work to ensure these contractors have thorough data collection protocols for identifying providers and obtaining complete documentation. States are concerned that if CMS' contractors are less persistent than states in obtaining provider records, contractors could unintentionally inflate states' PERM rates. Experience from states participating in the PAM Pilots has shown that obtaining adequate documentation can be the most labor-intensive part of claims audits. Thus, APHSA suggests that CMS collaborate with states to develop model letters, other processes, and guidance to ensure provider cooperation. States also verify medical necessity determinations with physicians and we encourage CMS to include this step in the contractor workplans, even though this might prove difficult in rural states where providers can be unavailable in some areas.

Review and Verification

- States are concerned that there is no specific provision for states to re-review audit findings or rebut initial error determinations. In some situations, states may be able to explain apparent errors by reviewing the case or expending additional effort in obtaining or interpreting provider documentation. Some errors could arise from the need for insight in interpreting states' medical 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. We encourage CMS to explicitly develop a formal process for states to re-review all errors before final error rates are established. In addition, we also encourage CMS to create provisions for providers to appeal medical findings portion or, alternatively, to create a mechanism by which providers could challenge medical error payment recovery.

- The interim rule does not indicate how fraudulent claims or providers under active state investigation will be handled. Should these claims count as errors, since they should not have been submitted in the first place? Should the federal contractor consult with states prior to contacting providers so as not to jeopardize ongoing fraud investigations? One approach might be to exclude claims for providers under active investigation from the quarterly sample states are to submit to CMS' PERM contractors.

- Another concern is state-specific error rates. APHSA believes 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. We are interested in the formula that will be used to calculate error rates. APHSA would appreciate the opportunity to allow states' statisticians to review and comment on the relevance and reliability of the methodology for determining the rates. APHSA suggests that CMS create an oversight or steering committee for the PERM contractor that includes state representatives. This steering committee could serve as a technical advisory panel for the PERM contractors scope of work and for resolving methodological issues that will arise during the course of implementing PERM. State experts will be in the best position to assist CMS' contractors in developing research and data collection protocols that ensure state error rates are valid and consistent.

Budgetary and Staffing Concerns

- Budget requests for state staff must be submitted far in advance, particularly in those states with two-year legislative cycles. However, the proposed random group of states that will be selected each year may make it difficult to predict what resources a given state will need in advance of the requirement. Unless CMS provides 100 percent funding for additional personnel required under PERM, states may be forced to shift state staff from other budgeted resources in order to comply with PERM requirements.

  Although we recognize that this might create statistical sampling complications by reducing the equal probability that any state could be selected, we request CMS to consider alternative methodologies that would permit states to know the schedule for yearly PERM audits in advance so that staffing requirements could be anticipated.

Corrective Action Plan Process

APHSA has several questions on the corrective action plan process. For example, 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 burden section of this interim rule and previous information collection proposals. We note that the 500 hours identified in the supporting materials may be insufficient to develop, implement, and monitor a corrective action plan. For example, if providers miscode claims or fail to adequately document their services in medical records, a corrective action might involve development of provider outreach and education to encourage better documentation and coding. Development and implementation of a provider outreach program could entail considerable staff time, substantially more than the 500 hours included in CMS' burden estimate for corrective actions. APHSA would like more information to better understand CMS' vision of the corrective action process so that states could more effectively plan for complying with the requirement.

In summary, as we have noted in our earlier comment letters, APHSA, NASMD, and NAPIPM are fully committed to reducing Medicaid and SCHIP errors. We recognize CMS' substantial effort in retaining federal contractors for the systems and medical components of PERM and CMS' continued interaction with NASMD members in exploring PERM eligibility approaches. We also encourage you to work closely with NASMD's members on the managed care components. We want to ensure that limited state and federal resources are directed toward this goal in the most cost-effective and productive manner. We believe more dialogue between CMS and states can help to explore these critical issues.

We would be pleased to meet with you at any time on these matters. Thank you for considering our comments. If you have any questions, please do not hesitate to contact me or Elaine Ryan at (202) 682-0100, ext. 235.

Sincerely,

Jerry W. Friedman
Executive Director

Submitter : Dr. Q. Michael Ditmore

Organization : Missouri Division of Medical Services

Category : State Government

Date: 11/04/2005

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-6026-IFC-7-Attach-1.DOC

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

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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.

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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.

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

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

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

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

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

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-8-Attach-1.DOC

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58261	Analysis and Response to Public Comments on the Proposed Rule	In FY2006 we will use a Federal contractor to estimate improper payments from medical and data processing reviews in the fee-for-service component of Medicaid. Will group States into three equal strata of small, medium, and large based on States' annual FFS Medicaid expenditures from the previous year, and select a random sample of an estimated 18 states to be reviewed. For subsequent years, our sampling methodology will ensure that each State will be selected once, and only once, every three years for each program.	A single State could be selected for the add-on programs in successive years. The first time a state is reviewed will likely be the most cumbersome for the contractor and the state. As much advance notice as possible would be appreciated in order to plan for staffing.
58262	Analysis and Response to Public Comments on Proposed Rule	The error rates produced by this selection will provide the State with a State-specific error rate.	Missouri disagrees that a State-specific error rate is required as the purpose of the IPIA is to determine a national error rate. The goal of a national error rate should be obtainable by combining the sampled States' data without necessitating a State-specific error rate. This will lead to unwarranted comparison of States when, as stated in, A. Purpose and Basis, there is wide variation in States' Medicaid and SCHIP programs. Tracking of errors by States should still be achievable for the corrective action feature.
58262	Analysis and Response to Public Comments on Proposed Rule	The States selected for review will submit the previous year's claim data and expenditure data, not otherwise provided by CMS.	Missouri is concerned that previous year's data already provided to CMS which is to be used for sample size per stratum may not agree with the same type of stratification as submitted in the quarterly data. Missouri is participating in the Payment Error Rate Measurement (PERM) project and chose to program each stratum based on the Medicaid Statistical Information System (MSIS) definitions but did not elect to use the existing state MSIS files. In particular, these files did not exclude adjustments nor include denied claims or premium payments.

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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.

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
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 : **Ms. Jeanne LaBrecque** **Date: 11/04/2005**

Organization : **Indiana Office of Medicaid Policy & Planning (OMPP**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC-9-Attach-1.DOC

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

November 3, 2005

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

Re: FR 70, No. 192, 10/5/05, Pages 58260 – 58277, Interim Final Rule with Comment Period

To whom it may concern:

This letter provides comments from the Indiana Office of Medicaid Policy and Planning (OMPP) on the proposed amendments and Interim Final Rule regarding 42 CFR Parts 431 and 457, estimating improper payments in Medicaid and SCHIP. The Interim Final Rule sets out the types of information that States would need to submit, and the requirements of States to allow CMS to conduct the medical and data processing reviews on adjudicated fee-for-service claims. Please find our comments below:

(1) Section V. Collection of Information Requirements, Page 58274, describes the level of resources required of States to supply the Federal contractor with information and to comply with the requirements of the rule. Specifically, the Interim Final Rule indicates "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)."

We request CMS further analyze the requirements for State resources to gain an understanding of the accuracy of this estimate. There will be substantial resources involved with providing medical and payment policies and data extracts annually, or for quarterly updates. The CMS-selected contractors will not be familiar with each State's medical and payment policies, and will therefore require a substantial commitment of the State's resources, from multiple program areas, and from the State's contractors.

In addition to supporting the audit activities, states are required to separately account for recoupment actions on identified overpayments as well as prepare, execute and monitor progress on corrective action plans. Since resources will be pulled from various state program areas and from multiple contractors, the State will be faced with a significant responsibility as it attempts to coordinate the work efforts of multiple state and contractor

staff members who will be interfacing with multiple CMS contractors. These facts, coupled with the volume of claims the Federal contractor will review, strongly suggests that CMS' estimate is understated.

The regulation is silent on how PERM relates to existing State Medicaid program integrity audit functions. Is it CMS' intent for PERM to supplant or enhance existing audit programs?

Many states, such as Indiana, require administrative budget estimates to be prepared, submitted, and approved well in advance of the need. Indiana Medicaid has not received budget approval for the added administrative resources necessary to support this initiative, since CMS had not issued final plans for the PERM model until recently. Please clarify how States that have not received budgetary approval to support this initiative can provide the required support? Will CMS consider fully funding these costs until such time that they can be included in an approved State budget?

Regardless of the actual number of hours necessary, the tasks associated with supporting PERM will require States to move resources from other priorities. There will also be a drain on contractor resources. To plan for this, is critical that States have a clear understanding of CMS' requirements, so that we can more accurately assess the resources needed to support PERM. Furthermore, we request that FFP be increased to 100% for the hours necessary to support this federal initiative.

(2) Section V. Collection of Information Requirements, Page 58274, describes the requirements of the States. While we recognize that one requirement is "repricing of claims the contractor determines to be in error," we believe that the regulations must provide and fully describe the opportunities that states will have to review, discuss, comment, and approve the Federal contractor's findings, prior to them becoming final. Given that each state Medicaid program has unique medical and payment policies, it is imperative for states to have an opportunity to review, discuss, comment, and approve the findings, in order to mitigate situations where the contractor incorrectly identifies an error, before reporting it to CMS.

(3) Section IV. Provisions of the Interim Fine Rule, Page 58272, describes that CMS will "adopt the recommendation to use a Federal contractor to estimate medical and data processing error rates for Medicaid and SCHIP based on reviews of adjudicated claims." The OMPP believes that the Interim Final Rule should describe the performance standards of the contractors and the ways that CMS will monitor compliance of those standards. CMS should be mindful and sensitive to the learning curve required of the contractors and closely monitor the contractors' performance, to ensure that states are not required to devote unnecessary resources providing assistance to the Federal contractors. There likely will be an additional burden to states in dealing with three separate contractors, whose responsibilities may somewhat overlap.

Thank you for the opportunity to submit comments on the Interim Final Rule. We look forward to receiving CMS' response to these and other comments submitted in response to this initiative. Please feel free to contact Pat Nolting of my staff at (317) 232-4318 if you would like any additional information.

Sincerely,

Jeanne M LaBrecque
Director of Health Policy and Medicaid

Submitter : Mr. John Chappius **Date:** 11/04/2005

Organization : Department of Public Health and Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC-10-Attach-1.DOC

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
GOVERNOR

JOAN MILES
DIRECTOR

STATE OF MONTANA

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PO Box 4210
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November 4, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop: C4-26-05
Baltimore, MD 21244-1850

Attention: CMS-6026-IFC

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

Dear Dr. McClellan:

The State of Montana 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). The State of Montana appreciates CMS' decision to accept the recommendations of commenters and retain a federal contractor for Medicaid and SCHIP PERM. Even though, the State of Montana generally supports the federal contractor approach for Medicaid and SCHIP PERM, we have some concerns with some components of CMS' implementation plans:

- transparency and participation in the rule making process, particularly for development of the eligibility and managed care components of PERM;
- requirements on states that exceed those described in the interim rule;
- 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' workplans, work statements, and protocols.

As we have indicated in our previous comments on this subject, we believe that CMS' announcement does not contain adequate information to evaluate fully their impact on states and soundness.

State Burden

- The State of Montana encourages CMS to enter into a dialogue 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. We suggest that CMS establish a steering committee or other advisory group that includes multiple state representatives to help ensure that the PERM contractors consider all the logistical issues and address potential data collection issues before beginning their onsite and interactive work collecting medical review policies, manuals, and system documentation. For Montana, obtaining systems documentation is likely to require assistance from our fiscal agent, which may involve unanticipated additional support expenses.

- We question whether full administrative cost burdens of these proposals have been incorporated into the announcement. We note that CMS nearly doubled states' burden hours estimates from the July (830 hours) to the August 2005 (1,630 hours) information collection notices, but these estimates are still insufficient, particularly during the startup of a complicated program with many variables and state-to-state variation.

  We suggest 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. It seems likely that the first PERM round will be the most onerous, where we are essentially transferring a large body of medical review, systems, and provider information knowledge to PERM contractors.

- The State of Montana objects to inclusion of denied claims in the sample universe. The proposed regulations 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, and therefore we believe that denied claims should be removed from the sampling universe.

- CMS has chosen not to use existing data collection tools such as the Medicaid Statistical Information System (MSIS) or the Medicaid Eligibility Quality Control (MEQC) program. This approach will result in duplication of effort and most likely will lead to results that will be difficult to reconcile between the two systems. It is not the impression of states that these systems could not be used in the process because they are too old or not included in the statutes. CMS should consider how the methods can be used to prevent the duplication of effort and make sure that a coordinated approach is used that will result in a process that is as seamless as possible.

- In addition, the federal contractor will likely need more information from the states than specified in the interim rule. To review and assess payment error accuracy, contractors will need adjudicated claims data and medical policies, as well as a number of dynamic reference files/subsystems in state 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.

States expect that contractor assistance during any provider appeals may not be available. States should hope for the best outcome however, planning for less than optimal results is prudent. This is not specifically addressed in the rule and states should expect to shoulder the burden in this area. The rule indicates that the contractor will be reimbursed on a per review basis, which provides an incentive to identify errors quickly and keep contractor expenses to a minimum. Due to the sometimes-lengthy appeal process, in order for states to ensure that states are prepared effectively handle this effort; it makes sense to expect their involvement throughout the process.

We encourage 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.

- States have experienced 50 percent compliance rates for provider request for records with out follow up and even higher ratios of incomplete responses. In order to insure that a high rate of provider response is achieved, states will need to work with providers and follow up on request to achieve high response rates and accurate responses.

- Finally, providers historically are very guarded about the confidentiality of their files, and can be expected to provide a challenging environment to contractors requesting records. Many state programs routinely request records multiple times and still must resort to creative tactics, such as having fiscal intermediaries assist in getting complete records. The State of Montana encourages CMS to implement incentives in PERM contractor's statements of work to ensure these contractors have thorough data collection protocols for identifying providers and obtaining complete documentation. We are concerned that if CMS' contractors are less persistent than states in obtaining provider records, contractors could unintentionally inflate states' PERM rates.

Review and Verification

- The State of Montana is concerned that there is no specific provision to re-review audit findings or rebut initial error determinations. In some situations, we may be able to explain apparent errors by reviewing the case or expending additional effort in obtaining or interpreting provider documentation. Some errors could arise from the need for insight in interpreting states' medical 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. We encourage CMS to explicitly develop a formal process for states to re-review all errors before final error rates are established. In addition, we also encourage CMS to create provisions for providers to appeal medical findings portion or, alternatively, to create a mechanism by which providers could challenge medical error payment recovery.

- The interim rule does not indicate how fraudulent claims or providers under active state investigation will be handled. Should these claims count as errors, since they should not have been submitted in the first place? Should the federal contractor 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.

- Providers in Montana are under contract with the state; if they object to an error finding, to whom would they appeal, the state or the contractor? The absence of any formal auditing or appeals in this process would be unprecedented in the federal-state Medicaid program relationship.

- Another concern is state-specific error rates. The State of Montana believes 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 we have some ability to review and validate CMS' PERM contractor findings, before a corrective action plan or state error rate is established. Finally, we are interested in the formula that will be used to calculate error rates.

Budgetary and Staffing Concerns

- Budget requests for state staff must be submitted far in advance for the State of Montana because we have a two-year legislative cycle. However, the proposed random group of states that will be selected each year may make it difficult to predict what resources we will need in advance of the requirement. Unless CMS provides 100 percent funding for additional personnel required under PERM, we may be forced to shift state staff from other budgeted resources in order to comply satisfy PERM requirements.

  Although we recognize that this might create statistical sampling complications by reducing the equal probability that any state could be selected, CMS may want to consider alternative methodologies that would permit states to know the schedule for the yearly PERM audits in advance so that staffing requirements could be met.

Corrective Action Plan Process

The State of Montana has several questions on the corrective action plan process. For example, 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 burden section of this interim rule and previous information collection proposals. We note that the 500 hours identified in the supporting materials may be insufficient to develop, implement, and monitor a corrective action plan. For example, if providers miscode claims or fail to adequately document their services in medical records, a corrective action might involve development of provider outreach and education to encourage better documentation and coding. Development and implementation of a provider outreach program could entail considerable staff time, substantially more than the 500 hours included in CMS' burden estimate

for corrective actions. The State of Montana would like more information to better understand CMS' vision of the corrective action process so that states could more effectively plan for complying with the requirement.

Finally, we look forward to working with CMS on the managed care and eligibility components of PERM. We want to ensure that state and federal resources are directed toward this goal in the most cost-effective and productive manner. We believe more dialogue between CMS and states can help to explore these critical issues.

Thank you for taking the time to review our comments. If you have any questions, please contact Steve Kranich, Program Integrity Supervisor, at 406-444-9356 or Mary Dalton, Quality Assurance Division Administrator, at 406-444-5401.

Sincerely,

//s Mary Dalton for John Chappius

John Chappius
Deputy Director

cc: Mary Dalton
Russ Hill
Steve Kranich

Submitter : Dr. Leighton Ku **Date:** 11/04/2005

Organization : Center on Budget and Policy Priorities

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-6026-IFC-11-Attach-1.DOC

Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
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center@cbpp.org
www.cbpp.org

November 2, 2005

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

By electronic submission at www.cms.hhs.gov/regulations/ecomments

SUBJECT: Comments on Interim Final Rule on Medicaid and SCHIP Payment Error Rate Measurement: CMS-6026-IFC

Dear Sir or Madam:

We are writing to comment upon the interim final rule published in the October 5, 2005 *Federal Register* on the Payment Error Rate Measurement (PERM) regulations for Medicaid and SCHIP.

Use of a contractor. We generally support the policy of using a federal contractor to collect the sample of claims and conduct the medical reviews for PERM for about one-third of states each year. This substantially reduces the heavy administrative burdens that state Medicaid and SCHIP agencies would have had to bear under the original proposal that all states collect the PERM sample and conduct reviews each year.

Public review and comment on operational PERM policies. We do *not* believe that use of a contractor exempts CMS or its contractor from having any public review of the procedures about how medical reviews are conducted and how an error is determined. The interim regulations completely omit from the regulatory language any discussion of the components of a medical error review or how an error would be determined. In response to those who proposed that there be a task force or advisory group to review PERM protocols, CMS said this was no longer needed because a contractor will do the work. If anything, the use of a contractor *increases* the need for outside oversight and review, because the procedures will be less transparent to states and other parties who are affected by the policies. CMS should make arrangements for a public review of PERM protocols and the contractor's performance, including input from state agencies, provider organizations and other public entities.

Two critical topics in medical error reviews. There are two critical areas that affect the accuracy of error rates, but discussion of these topics was omitted from the interim regulation:

- Medical necessity in Medicaid is defined and operationalized differently in each state. A national contractor will not be able to ensure that its assessment of medical necessity comports

with state policy. The state agency should be the ultimate arbiter of errors in this area, insofar as the question of whether a payment is improper in Medicaid is ultimately a question of whether it complies with state-specified policies.

A new section of the regulations (Section 431.980) should be added which specifies that when the contractor determines, as part of its medical review, that if an error is detected, this case will be submitted to the state agency, with all appropriate documentation, which can decide whether to re-review the case. If the state agency can demonstrate that there is no error under its policy, the error determination will be nullified and appropriate adjustments to the state's error rate will be made.

- In the PAM/PERM pilot projects, the most common error found was the lack of or inadequate documentation. This means that the reviewer was unable to determine whether an error occurred. Analyses by OIG found that the majority of cases in which there is inadequate documentation **are not** errors, but occur because a provider cannot readily provide the documentation required.[1] In many cases, there were missing data because the request for medical records was sent to a wrong address (so the provider did not get the request) or because the medical records were not under the control of the provider (e.g., a pharmacist may not have the documentation to determine if a physician prescribed the appropriate medication or a physician may no longer be practicing at the clinic or hospital where he saw the sampled patient). As a further example, the states of Louisiana, Mississippi, Alabama and Florida may find their error rates exaggerated because many health care providers may have lost their records as a result of Hurricanes Katrina or Wilma or may have great difficulty providing records promptly because of the problems caused by the hurricanes.

  Counting cases with missing documentation as errors inherently exaggerates estimates of errors and undermines the credibility and integrity of the PERM process. Under CMS' current plan, the contractor has little incentive to put the extra effort needed to collect documentation which is not easily obtained. It is easier for the contractor to simply count cases as errors due to inadequate documentation and thereby minimize its costs.

  A new Section 431.990 should be added that specifies that when the contractor is unable to obtain sufficient information to determine whether there was an error, the case with inadequate documentation should be eliminated from the sample, so that it counts *neither* as an error nor as an approved case. The contractor should continue to keep track of these cases in order to improve future performance, but not count these cases as errors. This will give the contractor an incentive to do a better job collecting data and will provide more accurate estimates. As an alternative, the contractor could develop a statistically appropriate method to estimate the proportion of missing data cases which are actually in error and use that method to adjust the error rates.

Public meetings for eligibility workgroup. CMS stated that it was not certain about how to proceed with eligibility error reviews and that it would form a workgroup to examine this important issue. We believe that members of the public, including state officials and other interested parties

[1] HHS Office of the Inspector General, "Review of Providers' Responsiveness to Requests for Medical Records Under the Comprehensive Error Rate Testing Program," Sept. 2004.

(including consumer groups) should be able to participate in such meetings. At the very least, CMS should comply with requirements under the Sunshine Act. It is our understanding that this workgroup has already been formed and there was no opportunity for public participation. This should be changed.

Remaining PERM policies should handled as regulations. Finally, we expect that any rules that are formulated regarding eligibility or managed care error reviews related to PERM will be published in the *Federal Register* and be subject to public comment.

Thank you for giving us the opportunity to comment. If you have any questions or if you wish to notify us about any public input to the eligibility workgroup, please contact me at 202-408-1080 (email ku@cbpp.org).

Sincerely,

Leighton Ku
Senior Fellow

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-12-Attach-1.DOC

October 31, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-6026-IFC, Mailstop C4-26-06
7500 Security Boulevard
Baltimore, MD 21244-8012

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

Dear Sir:

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

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

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

Thank you for considering our comments.

Sincerely,

Q. Michael Ditmore, M.D.
Director

QMD/sb
Attachments