Submitter : Mr. Jerry Friedman

Date: 09/27/2006

Organization : American Public Human Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC2-11-Attach-1.PDF

September 27, 2006

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

Attention: **CMS–6026-IFC2**

Re: Interim Final Rule with Comment Period: Medicaid and the State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement

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 (PERM). APHSA is commenting on the interim final rule published in the August 28, 2006, *Federal Register* (71 *FR* 51050) for the Centers for Medicare and Medicaid Services (CMS). Please be assured that the state Medicaid agencies are fully committed to reducing Medicaid and SCHIP errors.

We appreciate that CMS addressed in its August 28, 2006, interim final regulation a number of the issues we raised in our previous comments on July 25, 2006, on the May 28, 2006, Information Collection Notice and our November 5, 2005, comments regarding the interim final rule published on October 5, 2005, in which CMS described the proposed implementation of a federal contractor plan. Still, there are a number of issues for which states need clarification and wish to offer recommendations.

As discussed in our comments below and based on the feedback provided by states selected for the first "production cycle" of the PERM project, APHSA respectfully requests that the eligibility component be delayed until federal fiscal year 2008 or to the point in time that the many critical issues and questions are resolved. In order to achieve this goal, we believe that CMS should facilitate a more comprehensive dialogue by providing additional details on PERM prior to moving forward with implementation in other states.

There are a number of confusing issues and areas where states simply lack sufficient information to fully evaluate CMS' PERM plans and develop and implement the plans they required to ensure they are in compliance. Specifically, states still have received limited information with regard to implementation of the eligibility component of PERM, development of the samples, and review of the cases and they lack clarification for how to address the duplication of effort presented by the Medicaid Eligibility Quality Control (MEQC) and PERM eligibility review processes. In turn, without such information, we believe CMS has made overly burdensome requirements for states, particularly for those selected for review in FY 2007, to comply with its proposed plan for Year 2. We believe our comments offer reasonable recommendations for how CMS should proceed based on the information that is available to us. However, we also strongly recommend that CMS convene workgroups or advisory groups to identify and resolve remaining challenges.

In addition, although APHSA was encouraged that CMS developed a difference resolution process, providing more information about the scope of such a process is essential for states to assess its value and feasibility.

As in our previous comments, we continue to believe that CMS can take additional steps to assist states attempting to comply with the PERM project. For example, to improve understanding and consistency across states, CMS could develop a matrix or chart explaining the options and requirements associated with each component of the PERM process.

The following comments and suggestions provide a more detailed explanation of our concerns and requests for clarification based on the latest notice and pending issues, including:

- Significantly improving communication and coordination with states and delaying implementation of additional components of the PERM review process until questions and challenges have been resolved;
- Eliminating duplicative and unworkable processes and requirements that have been identified;
- Providing clarification on several aspects of the eligibility review, including the sampling plans;
- Addressing concerns with the PERM reviews and their impact on the State Children's Health Insurance Program (SCHIP);
- Providing more detail for corrective action plans;
- Reevaluating the factors and issues impacting CMS' burden estimate; and
- Considering other general issues that states have raised that could facilitate implementation of the PERM project.

Communication and Coordination with States

APHSA is extremely concerned with the communication to and coordination with states to date, specifically between CMS and the states and between the national contractor and the states selected for Year 2 of PERM. Despite CMS' stated goal of beginning Year 2 of PERM on October 1, 2006, as of one week before this date the agency had not yet issued additional detail and direction to the states to meet the requirements outlined in the August 28, 2006, interim final regulation, and had failed to answer inquiries made by states and representatives of states to the central CMS office and the regional offices.

Specifically, the final regulation (page 51069) states that "The SC [statistical contractor] will provide detailed instructions and technical assistance to each selected State on the stratification process." APHSA has been contacted by several Year 2 states requesting not only detailed information regarding the development of their eligibility plan, but also basic questions in preparation for PERM reviews. Still, neither the states nor this organization has received sufficient, timely information from CMS. The following issues provide further information on state concerns:

- CMS states that it conducted a workgroup with two states identified by APHSA. We also appreciate that CMS has been available to participate in one meeting and one conference call to discuss the CMS process for issuing guidance on PERM. However, we believe CMS can and must use all available processes and modes to strengthen its communication with states to disseminate basic information as well as to improve collaboration and input-seeking processes.

- As stated in Section 431.978 (page 51078), CMS is requiring states to submit their eligibility sampling plans by November 15, 2006. Given the significant undertaking in resources and planning required to implement PERM, we believe it is wholly inappropriate for CMS to proceed with implementation of the eligibility reviews and managed care components as outlined in the rule. Instead, if CMS intends to proceed with PERM reviews, we recommend that the agency delay implementation of these additional components until the problems and concerns are addressed and the agency has the capacity to provide states with sufficient information to enable them to proceed in a timely manner.

- CMS and its national contractor should provide states with an integrated time-line or project plan for a PERM sampling year. A project plan should clearly identify all three contractor activities as well as any expected state responsibilities (claim delivery and sampling schedule dates, required state documentation due dates needed by contractors to comply with CMS contract deadlines, medical necessity and process reviews, state sampling plan response times, eligibility timelines integrated with MEQC required deadlines, etc.). States have also suggested that for each PERM state, contractors should prepare monthly project planning documents to CMS and the states with explanations of delays, barriers, or other issues that have arisen and the contractor's plans to rectify any problems areas.

- APHSA recommends that CMS develop a PERM advisory committee that would be available to address the implementation issues that Year 1 PERM states already have reported to APHSA and to CMS. Such a group could serve to enhance CMS' understanding of the potential duplication that may occur and to resolve some of the challenges that will no doubt continue to arise throughout the initial years of the PERM process. Further, we note that CMS has not convened such an advisory or other workgroup to address challenges and questions specific to the application of PERM to SCHIP.

Selection of States

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 state will need to carry out PERM activities or support. As a consequence, there will be time delays while state resources are identified to support the national contractor during start-up. If not forthcoming, states could be improperly held responsible for time delays. Even temporary positions are time-consuming to establish at the state level. Retention of experienced state staff for the PERM project will not be possible on a once-every-three-years cycle. It increases the likelihood of incomplete or inaccurate information being given to the national contractors.

Claims Reviews

APHSA requests that CMS reconsider the decision to include "Denied Claims" as a stratum for analysis in PERM. Based on feedback from a number of states, this decision would result in significant technical and logistical problems when the state attempts to produce a list of "adjudicated denied claims," and it would add considerably to the state's burden while providing information to the SC. In addition, the necessity of tracking the rebillings of the denied claim would add to the burden of providing information to the documentation/database contractor (DDC). Further, the difficulty in determining a sample size based on dollar value of the stratum would be most difficult considering the dollar value of a denied claim is zero. While the task of determining improper denials is a laudable one, including Denied Claims in the current PERM methodology is inappropriate. APHSA recommends that CMS remove denied claims as a review stratum for FY 2007 PERM States. Instead, states would be willing to continue to work with CMS to develop a more appropriate methodology for measuring error in denied claims which could be implemented in a future PERM cycle.

Regarding the review of claims and development of the error rate, APHSA wishes to emphasize that the IPIA is a federal mandate directing federal agencies to develop a national error rate. As such, we request that in its management of the national contractor and communication with other federal agencies, CMS make clear that the IPIA is not

intended to root out provider fraud or challenge program enrollment decisions, since these functions are under the purview of other federal and state initiatives.

Duplication Issues

APHSA appreciates CMS' dedication to minimizing the duplication of effort and minimizing the burden to states throughout the PERM process. However, based on the interim final rule, we are concerned with two major issues where additional consideration is necessary.

Separate and Independent Requirement

In CMS' response to comments on page 51064, the agency indicates that it will "...provide in the regulation that the agency conducting the PERM eligibility reviews must be functionally and physically separate and independent from the State agency responsible for Medicaid and SCHIP policy and operations, including eligibility determinations." APHSA respectfully disagrees with this new requirement based on a number of problems this would present for states. Further, we believe that neither CMS nor the commenter requesting this process provided evidence to support the assertion that current organizational structure presents a conflict of interest. As such, we request that CMS not impose this new requirement on states. Further, we believe this new requirement has implications for several aspects of the PERM review process which in turn necessitates reconsideration by CMS.

States have raised a number of concerns about the implications such a requirement would have both on their current operating and organizational structures as well as the resulting increase in burden from conducting PERM reviews.

Above all, in this rule and in previous guidance CMS indicated that it expects states to utilize staff that are already familiar and working in the relevant issue areas to contribute to the PERM workload. However, this new requirement would make this physically and fiscally unworkable in many states and instead compel states to create a new entity in the state where staff and expertise do not currently exist. States utilize a range of organizational structures that already meet state and federal statutory requirements and guidelines for quality and integrity. Further, this requirement is not required in either the Food Stamp or Temporary Assistance for Needy Families (TANF) programs, and as such states believe should not be imposed upon the Medicaid program. This requirement would be problematic for states on several levels. For example:

- This requirement will significantly increase the cost of PERM reviews. Specifically, it would require increased staffing in many states. At this late date, states are not likely to have the capacity to absorb these costs through shifts internally nor on a contractual basis, nor do we believe they should.

- Many states have separate divisions within their Medicaid agency that work on issues related to various components of the PERM process. However, these are typically separate and independent of each other and generally report to different authorities.
- Some states have their MEQC unit housed within the program integrity (PI) section of the Medicaid agency. The program integrity section may be administratively separate from the eligibility policy and eligibility determination process. APHSA requests that CMS consider the contradiction that such an organizational arrangement is satisfactory with CMS for Title XIX and Title XXI, but under this rule would not be satisfactory for PERM.
- Some states have their MEQC unit as a separate division from eligibility, however the staff are part of the same overall organizational structure.
- MEQC workers may be housed in various regional offices. To be physically and organizationally separate is not feasible since MEQC staff are likely to be responsible for some pieces of the PERM review process.

APHSA requests the removal of this new provision. However, should CMS refuse to reconsider this issue, we request that CMS provide additional guidance to states on the following:

- The rule does not discuss the impact of this new requirement for states that use a fiscal agent. For example, will a state be able to use its current fiscal agent to conduct its PERM work via a separate contract?

MEQC–PERM Substitution Issues

In this interim final rule, CMS requests input on the duplication that PERM and MEQC reviews would impose when conducted in the same year. APHSA recognizes that there are different laws governing the two processes and that the PERM eligibility requirement is only once every three years. To require states to conduct simultaneous studies for PERM and MEQC at the same time will result in states doing eligibility reviews twice; will cause excessive burden on states' resources; and does not ensure that limited state and federal resources are directed efficiently and cost-effectively. APHSA believes there should be only one review conducted by the federal government that meets the requirements for both mandated reviews. Regardless of the methodology used, that is, if the MEQC methodology is substituted for PERM or vice versa, no disallowance of federal funds should apply to the PERM review.

In addition, individual states have provided considerable input to CMS on options for addressing these issues. APHSA supports a collaborative process between states and CMS to resolve this issue and to minimize the duplication of effort between MEQC and PERM eligibility reviews. We appreciate that CMS convened one workgroup to discuss this issue and requests that it make the recommendations of this group public. APHSA would be happy to work with CMS to convene a representative group of states to provide additional input.

Further, APHSA wishes to emphasize that in its previous notices CMS indicated that the PERM–MEQC substitution would be available as an option to states. Thus, in preparation for Year 2, the relevant states approximated their resource needs and workload based on this option. For many states, the possibility of not permitting this option would present a significant setback in their preparations and allocation of resources.

Eligibility Reviews

APHSA believes that states currently do not have the information they need to sufficiently determine how best to develop the sampling plan and conduct the eligibility reviews since CMS has not provided sufficient information about all the options that are available to states regarding the allocation of their staffing resources and PERM programmatic requirements.

PERM–MEQC Substitution

Specifically, in the August 28, 2006, interim final rule, CMS indicated that it had not yet finalized its analysis of the associated legal and policy matters regarding the option to use the (PERM) reviews to satisfy MEQC statutory and regulatory requirements.

States have informed APHSA that they are considering using the PERM eligibility reviews to satisfy requirements for the MEQC program under 1903(u) of the Act. However, they will need clarification from CMS before proceeding. In order to use resources most efficiently on the part of states and CMS, APHSA recommends that CMS notify states immediately regarding the decision on this issue. As has been discussed in our previous comments, states believe that there would be considerable duplication of effort if CMS were to prohibit states from utilizing the option of MEQC substitution. States believe there are several ways to address this and minimize burden for all stakeholders, and would be happy to provide further consultation to CMS on these issues. For example, one solution that has been proposed by some states is to waive the MEQC reviews during the year a state is scheduled for PERM. Specifically, APHSA was informed by one state that it recently completed a year under "Special Project" status, where the state conducted targeted reviews in place of the traditional MEQC.

Sampling Plans

APHSA appreciates that CMS has extended the deadline for submitting the eligibility sampling plan for states selected as Year 2 of the PERM project. However, even this revised November 15, 2006, deadline provides insufficient time for states to develop and be prepared to implement an eligibility review plan and process in compliance with CMS' proposal.

APHSA also has learned that states need guidance and information in addition to what already has been provided regarding sampling plans. Specifically, states are requesting additional guidance on the following issues:

- The actual sample size and whether CMS requires 500 samples for Medicaid and 500 for SCHIP, or if CMS is intending that there be a total of 500 samples for the two areas.
- Deadlines for providing claim information to the national contractor. Regarding this issue, APHSA requests that CMS consult with states to ensure sufficient time is provided for states to identify the amount of claims paid for each case.
- The relationship, if any, between the samples for claims and eligibility reviews.

Fraud Investigations

On behalf of the many states who have contacted APHSA on this issue, APHSA strongly disagrees with CMS' decision to include claims from providers that are under active fraud investigation in the universe of claims from which a sample will be pulled. We hope that CMS would agree that all steps should be taken to ensure that states' fraud and abuse and program integrity investigations are in no way jeopardized. As such we request that you reverse this decision. Among the problems we believe this decision could lead to are:

- Claims are likely to result in a decrease in response from fraudulent and abusive providers, which in turn would skew the error rate to an inappropriately inflated rate.
- There is no method for identifying false, fraudulent, or abusive claims in an automated claims payment system or through manual prior authorization. Thus, the only way to determine that type of error is to interview recipients and/or review medical records, which would be an undue burden on states to conduct all the time. APHSA holds that it is unrealistic to believe that states can conduct such reviews on a regular basis.
- Providers could be made aware that their claims are being reviewed, after which they may take various steps to alter or destroy documentation essential to an investigation. This is of particular concern to states with regard to complex and costly investigations.

Eligibility Review Process Details

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

It is also unclear whether the sampling unit is a case or an individual beneficiary within a case. There are references to a "case based methodology" (page 51065), "sample individual beneficiaries" (page 51074), and "individual beneficiary cases" (page 51075). APHSA requests further clarification on these terms and respectfully recommends that CMS consult with states or convene a workgroup that can provide additional input on the differences between these terms and implications for the implementation of PERM.

In general, APHSA believes that in reviewing cases, CMS should limit the review to determining whether or not the state followed the state's eligibility procedures correctly. CMS should not require further case scrutiny, including additional verification procedures and documentation beyond those currently required by the state. Doing so would add considerably to state administrative burdens and constitute another cost shift to states. It would also place additional application burdens on program participants and drive down participation rates.

New Federal Guidelines

APHSA requests that CMS clarify that the new citizenship documentation requirements, as mandated by the Deficit Reduction Act of 2005, will not be a component of PERM reviews in FY 2007. This policy been in effect less than a year, during which time both the federal government, including CMS, and states have been making a good-faith effort to implement this provision. However, given that CMS released a State Medicaid Director letter in mid-June and that federal interim regulations were issued in mid-July, states had very limited time and information available to guide them as they attempted to come into compliance with the statute.

Further, the federal requirement that beneficiaries have a "reasonable opportunity" to get documentation of citizenship or identity means that many may have had their certification extended beyond 12 months.

States believe that it would be an undue burden to include any new mandatory federal eligibility or documentation changes in the first year they are implemented. During this time the federal government and states are undertaking rigorous efforts to update their systems and provide training to all affected employees and providers.

SCHIP Reviews

Administrative Cap

In its response to commenters, on page 51063, CMS states that "...State submission of information on Medicaid and SCHIP program performance is an ongoing administrative requirement, States will be reimbursed at their normal administrative match for conducting the eligibility reviews and associated activities." CMS also stated in its response to commenters that it was not considering exempting the cost of the PERM-related expenses from the 10 percent SCHIP cap on administrative expenditures.

Instead, APHSA and the states believe that the PERM workload will add significantly to existing staff workloads. As such, we respectfully request that CMS reconsider this reimbursement decision so as not to pit the funding for PERM against the funding for SCHIP. We believe this is especially warranted in light of the shortfalls in funding that at least 17 states are anticipating in FY 2007. The IPIA is a federal mandate to create a national error rate. The IPIA imposes no mandates on states, and does not confer

authority on any federal agency to impose any cost burdens on states. Therefore, the costs should be borne by the federal government and not shared by the states, contrary to CMS' statement.

We urge CMS to reconsider this point, since several states are expecting PERM will have a significant impact on their SCHIP programs. To this end, we request that CMS revisit this issue and conduct a legal and regulatory analysis to identify any possible means of considering the PERM administrative expenditures so that they are not treated as part of the states' SCHIP administrative expenditures.

APHSA and the states wish to work with CMS on this issue to ensure that the cost of the eligibility reviews do not reduce the number of children who can be covered.

Methodology

States also request that CMS reconsider its interpretation of erroneous claims with respect to SCHIP reviews. In some states, eligibility is determined for both Medicaid and SCHIP within an integrated eligibility system, and a request for health care coverage is considered an application for Medicaid or SCHIP. Further, full-benefit Medicaid or SCHIP beneficiaries may be eligible for the exact same health care coverage package. Therefore, it is our continued assertion that payments made for SCHIP recipients who through PERM review are determined ineligible for SCHIP but eligible for Medicaid should not be considered totally erroneous.

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

Provider Participation and Verification of Contractor Findings

APHSA recommends that CMS conduct further analysis and revision of the PERM provisions as they relate to the compliance of providers and the intersection of PERM and Health Insurance Portability and Accountability Act (HIPAA) confidentiality issues. States have and will continue to make every effort to obtain information from providers when necessary. However, CMS should consider the common state experience that providers historically have been very guarded about the confidentiality of their files. As we have stated in previous comments, this is likely to pose a challenging environment to any contractor requesting those records. Above all, APHSA recommends that CMS not define a claim error after 90 days or some other arbitrary deadline which, based on states' experience, has proven to be insufficient. As such, APHSA recommends that CMS provide additional guidance and clarification on the following issues:

- States need additional information on whether the contractor will cite CMS or the state's authority when requesting medical records from providers.
- APHSA also requests that CMS provide clarification as to how the contractor will work with states if a provider refuses to provide the required records based on privacy rules to the national contractor, who is expected to address and resolve the provider's concerns. That is, will states be expected to contact the provider to avoid having the claims labeled as an error?
- APHSA requests that CMS provide further guidance to states on how to address situations where information cannot be collected because facilities are closed or are no longer in operation and whether over-sampling may be appropriate to address this issue. Although states may have statutes or policies in place that indicate that facilities have to maintain their records for a given number of years, finding the person responsible for retrieving and copying the record can be problematic and resource-intensive.
- APHSA requests that CMS notify states how the contractor will address HIPAA complaints, both those that are directed to the contractor and those that may come directly to the state.
- In addition, states will need guidance and information on how the transition to the NPI will impact the PERM process.
- APHSA requests that CMS provide additional information on the extent to which the national contractor seeks to obtain appropriate information from the providers. States request that CMS consider that they often must make repeated attempts to obtain such information and do not wish to be penalized for the contractor's limited efforts to obtain necessary information.
- States request information on how the contractor will identify where the records are stored; for example, will it be a blind letter to a billing address, which then will have to be forwarded within a provider's organization.

Difference Resolution Process

APHSA commends CMS for accepting recommendations from states to develop what has been termed the "Difference Resolution Process." In order to strengthen the efficiency and utility of this process for all stakeholders involved, APHSA requests that CMS consider the following:

- APHSA request that CMS provide clarification on the difference resolution process including the type and scope of information that will be provided in the monthly report from contractors. As currently defined in the interim final rule, we are concerned that CMS has not adequately provided for a process that will enable states to address all findings on all PERM issues.
- APHSA asks that CMS consider that in order to undertake a complete review of the contractor's work, states will also require access to the medical records submitted by the claim provider to determine if the state reviewers concur with the contractor's findings. Further, as CMS considers this issue, APHSA notes that it would be inappropriate for states to make this request since it would be a

duplicate and burdensome request to the providers. Further, states should be reviewing the same documentation used by the contractor in formulating their review.

- Although CMS did not so indicate in the interim final rule, APHSA requests clarification of any time limit that CMS intends to impose on this dispute resolution process going forward. We believe that such a time limit would impede states' ability to sufficiently review the cases on the report, especially if the review contractor (RC) is behind in its reviews and consolidates the majority of errors on reports that are toward the end of the review period to meet its deadline.
- States also request that CMS develop a process or mechanism by which the final report captures unresolved and disputed differences.

State Role and Relationship with Contractors

APHSA recognizes that the PERM reviews will be conducted once every three years. However, as CMS stated in the final rule, the entire PERM process is expected to take 23 months. Based on the experience of Year 1 PERM states and those that participated in the PAM/PERM pilot, we believe that there will be ongoing roles and responsibilities for state staff beyond the initial year of collection and provision of data provided for the national contractors. Further, CMS states in the interim final regulation that it is a state option to conduct the review of the contractors' findings. We submit that it would be imprudent for states not to conduct such a review of work and findings since the states *are* the experts on the cases and policies in their respective state. Thus, rather than an option, it can be expected that states will be compelled to conduct the following activities, among others:

- Retrieve records that the contractor cannot retrieve after 45 days.
- Review the monthly disposition report from the RC.
- Work with the RC to resolve any differences.
- File a written disagreement with findings.
- Provide technical assistance to the contractors.
- Notify contractor of quarterly claims adjustments.

APHSA also requests that CMS reconsider its determination that qualified staff will *not* be required to communicate with and fulfill requests from contractors. Given that each state Medicaid program operates under vastly different state policies and regulations, the expertise of trained professionals will be required to work with contractors to ensure they are receiving the appropriate data, information, and interpretation of materials and policies.

Adjustments to Claims

APHSA recommends that CMS fully examine states' claims adjudication process. Rather than focusing on the 60-day timeline, APHSA requests that CMS consider what timeframe will lead to the most accurate error rate. As CMS knows, states have different

timeframes for claims adjustments, and 60 days represents too narrow a timeframe for states to inform CMS contractors of any claims adjustments.

APHSA also request clarification of the statement on page 51060, "States will be able to obtain information identifying which providers have not submitted the requested medical records within the first 45 days of the initial request from the DDC." States are unclear as to whether it is a state responsibility to pursue this issue with the DDC or if the DDC will provide this automatically to the state at the appropriate time. States believe that if it is their responsibility, then CMS will need to require the DDC to keep each state informed of record requests so the state will know when the appropriate amount of time has passed and it can make this request to the DDC.

Corrective Action Plans

States believe the interim final regulation does not provide sufficient information regarding the scope and content of the corrective action plan. As such, APHSA requests additional clarification regarding the corrective action plans, including:

- In general, CMS should further clarify what the agency will require of states on corrective actions. For example, if a provider fails to properly code a claim or fails to adequately document a service in its medical records, will provider education be sufficient to address this error? States are not clear as to the appropriate corrective action expected by CMS, other than remedial education.
- Information on differences in the final reports that may account for the variations in the types of service delivery mechanisms utilized by states, that is, states that may have a high concentration of managed care versus states that are mostly fee-for-service.
- In discussing the corrective action plans, CMS does not indicate what if any role it will play in monitoring or evaluating the success of the states' plans. APHSA requests that CMS provide a rationale for requiring a corrective action plan from the PERM states when no implementation assistance, monitoring, or program evaluation will be provided by CMS. States have shared extensive information regarding their current program integrity efforts, and based on this, APHSA believes that the development and monitoring of additional corrective action plans will be duplicative. Further, it is clear that states already have an interest in and ability to develop, implement, and evaluate their own corrective action plans, which they are doing through their fraud and abuse and program integrity divisions.

General Comments

In its response to commenters, on page 51055, CMS states that "...the IPIA requires error rate measurement for these programs and does not cite lack of cost savings as a circumstance which would excuse us and the States from measuring improper payments."

As APHSA has noted in its previous comments, a number of states have informed us that the PAM/PERM pilots have demonstrated very low recoveries for PAM/PERM-identified overpayments. In addition, we believe that it is unnecessary and inappropriate for CMS to develop state-level error rates. The IPIA does not require state-level error rates, and, based on input from participating states, previous PAM/PERM pilots have demonstrated a negative return on investment. History has taught us that state error rates and subsequent state challenges to findings have failed to produce desired improvements, thus the MEQC option was adopted as a more effective and efficient alternative. As such, APHSA requests that CMS work with the Office of Management and Budget (OMB) to reconsider its guidance regarding the necessity and utility of state-level error rates.

APHSA also requests clarification on the statement in Section 457.720 of the interim final rule, which makes reference to PERM and State Plan Amendments, on whether states need to make specific reference to PERM in their State Plans.

Burden Estimate

Based on the revisions made to this interim final rule and extensive experience with quality control systems, APHSA respectfully disagrees with CMS' current burden estimate and believes that it grossly underestimates the time and resources that will be required of states.

APHSA noted that the interim final rule informed states that the entire PERM process for one cycle will take approximately 23 months rather than the 12-month fiscal period during which information is collected. In turn, APHSA requests that CMS consider that states will have to adjust their estimates and requests for the amount and duration of staff and financial resources required for successful completion of PERM reviews. As such, we request that CMS revise its burden estimate to reflect this new information. In addition, we request that CMS consider in its revision the following issues that all have an impact on the burden estimate:

- In this interim final rule, CMS states, "we have determined that SCHIP will be measured in the same year that states are measured for Medicaid." Thus, the estimate for "34 states" should be interpreted to mean "34 state programs in 17 states." However, the costs and burdens still appear to be presented as 34 states everywhere else in the document. APHSA requests that CMS consider the disproportionate effect this will have on smaller states, who are likely to have difficulty securing staff for such a large workload increase – particularly given the technical expertise that will be required to fulfill these responsibilities.
- Further, we wish to emphasize that many states have a two-year legislative cycle. Budget requests for additional staff must be made far in advance. With notification of states in advance of the review cycle, states will be able to prepare better for future years. However, the states selected for the Year 2 PERM project are at a disadvantage in not having time to predict staffing needs, and to hire and train qualified staff.

- Experiences of Year 1 PERM states.
- Additional costs not yet taken into consideration including provider education, the difference resolution process, technical assistance CMS indicates states will provide to contractors (which was newly cited in this regulation), and development of corrective action plans based on more detailed information from CMS of what these plans will entail.
- Underestimation of the time and effort of working with multiple national contractors. Rather than a single national contractor with subcontractors, CMS has chosen to hire three separate contractors. This method will impose additional requirements for all stakeholders involved to ensure the proper level of coordination necessary for a successful PERM project.
- Overlap with other ongoing integrity related efforts. CMS failed to take into consideration that there are several other programs and initiatives under way which audit and/or examine the integrity of a state's Medicaid program. APHSA strongly recommends that CMS conduct a comprehensive analysis of this effort to achieve its goal of minimizing the duplication of efforts. Specifically involved are the new federal Medicaid Integrity Program, continued oversight by CMS and the Government Accountability Office; and continuing MEQC audits of the eligibility program. Taken together, these represent a significant duplication of effort and expose gaps in communication between the federal agencies and divisions with the single CMS agency.
- CMS assessments on cost and data collection impact to state programs and state providers do not reflect the additional time and cost of provider appeals, etc. All findings on any appeal should be incorporated into calculations of final error rates for states regardless of CMS time frames.

We would be pleased to meet with you at any time or provide any additional information that may helpful to you 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 : Mr. Kelly Shropshire **Date:** 09/27/2006

Organization : Oklahoma Health Care Authority

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6026-IFC2-12-Attach-1.DOC

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

September 27, 2006

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

Attention: CMS-6026-IFC2

The Oklahoma Health Care Authority (State Medicaid Agency) respectfully submits the following comments regarding the proposed rule for the Medicaid Program and State Children's Health Insurance Program (SCHIP): Payment Error Rate Measurement.

IV. Provisions of This Interim Final Regulation
2. Eligibility

Bullet 8 states that in comments regarding conflict of interest, CMS provides that the eligibility reviews must be conducted by a State agency independent of the State agency responsible for Medicaid and SCHIP policy and operations (that is, is functionally and physically separate) including making the program eligibility determinations.

The Oklahoma Health Care Authority (OHCA) does not agree with this provision. The same state agency that is responsible for policy, operation and eligibility determinations should be allowed to perform PERM eligibility reviews as long as it is an independent function. In Oklahoma, the Oklahoma Health Care Authority is responsible for policy and operations and the State Department of Human Services (DHS) is responsible for eligibility determinations and MEQC reviews. The OHCA has relied upon DHS to conduct all of our PERM eligibility reviews during the PAM / PERM development years due to their working knowledge and experience of eligibility reviews. While DHS does perform both the eligibility determinations and eligibility reviews, the two functions are independent of one another. Responsible parties are housed in and report to separate divisions. The same organizational structure and work process has been employed and allowed since inception of our MEQC program. It does not seem feasible to require a change to a successful work process when the tasks and expected outcomes are basically the same. This provision would require the OHCA to contract this service out as no other state agency has the expertise to perform the reviews, resulting in duplication of effort and significantly more cost.

In closing, let us once again state that we appreciate the opportunity to comment on the proposed PERM regulations and hope that those issues that we have discussed in this letter will be considered.

Sincerely,

Mike Fogarty

Submitter : George Cummings **Date:** 09/27/2006

Organization : NH DHHS BII/QAU

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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