August 14, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Attention: **CMS–6150-P**

Re: Medicaid Program and Children's Health Insurance Program (CHIP); Revisions to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs; Proposed Rule

Dear Ms. Frizzera:

The National Association of State Medicaid Directors (NASMD) respectfully submits the following comments with respect to the proposed rule CMS-6150-P, Revision to the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs. This proposed rule was published in the July 15, 2009, *Federal Register*.

As you know, section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), specifies a number of new statutory requirements related to the administration of the PERM program. Included among these requirements is a prohibition of the Secretary from calculating or publishing any national or State-specific error rates based on the application of the PERM requirements until six months after a new final PERM regulation is published.

Moreover, the new final regulation is required to include: clearly defined criteria for errors for both States and providers; a clearly defined process for appealing error determinations by review contractors or the agency or personnel responsible for the development, direction, implementation, and evaluation of eligibility reviews and

associated activities; and clearly defined responsibilities and deadlines for states in implementing any corrective action plans.

The new final regulation must also provide that the payment error rate determined for a State shall not take into account payment errors resulting from the state's verification of an applicant's self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the state process for verifying an applicant's self-declaration or self-certification satisfies the requirements for such process applicable under regulations or otherwise approved by the Secretary.

CHIPRA also requires that the Secretary review the MEQC requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies.

Meeting this very stringent statutory timeframe to establish a new final regulation is a very difficult, if not impossible task, and we applaud CMS's efforts to meet this deadline. We have been sensitive to the timetable imposed by the statute and we have tried to offer our best counsel and advice to assist CMS in developing a proposed regulation that would result in a final regulation that is fully compliant with the statutory framework and achieves the CHIPRA goals. We and the states are committed to reducing Medicaid and CHIP payment errors We appreciate that CMS has been willing to meet with us and to listen to our concerns. However, we are greatly concerned that this new proposed regulation does not seem to differ much from the previous final regulation, which was deemed by Congress to be flawed and suspended until replaced by the final regulations developed by this rulemaking initiative. Therefore, in that light we offer the following comments.

<u>Comments on the Background</u>

- We acknowledge the difficult task CMS undertook attempting to coordinate the requirements of MEQC, Improper Payments Information Act of 2002 (IPIA), PERM and CHIPRA. The goal of aligning these regulations into one comprehensive set of regulations is difficult and because of this CMS should suspend PERM audits for the 2008, 2009 and 2010 federal fiscal years (FFY). During this time CMS should publish the new final rule, taking into account the experience of the audits for PERM cycle years 2006, 2007 and 2008. CMS should convene a work group of states and CMS staff to rewrite not only the Rule, but also all the audit guidelines and standards. In short CMS should take a "time out" and regroup before reinstating the audits for FFY 2011. The workgroup noted above should address not only the IPIA, PERM, and MEQC, but should address the other significant and many times redundant oversight already being provided CMS and other federal agencies.

<u>Sample Size</u>

- CHIPRA clearly and plainly requires CMS to vary the PERM sample size by state to minimize the impact on the states. The proposed regulations do not meet this requirements. In fact these proposed regulations directly contradict the CHIPRA

requirements. We suggest, PERM could adopt the sample sizes used in MEQC for both claims and eligibility thereby accomplishing two goals of CHIPRA (harmonizing PERM and MEQC and varying sample sizes by state).

- The proposed rule indicates CMS will estimate a state's annual sample size for claims review at the beginning of the PERM cycle, based on the state's previous performance under a prior PERM cycle. This sample size variability will make it extremely difficult for states to manage resources. What is the timeframe under which states will be notified of the sample size? What are the requirements for CMS and/or contractors to meet the specified timeframe? We suggest adopting specific timeframes for CMS and contractor notification that provide sufficient time for state resource planning.
- The proposal indicates that the maximum sample size for eligibility would be capped at 1,000 cases. Does this mean 1,000 cases for Medicaid and 1,000 cases for CHIP (or a combined 1,000 cases for both Medicaid and CHIP)? Sample caps at 1,000 Medicaid and 1,000 CHIP could result in staffing issues for states. If a state were required to complete 2,000 active reviews in their next PERM cycle they may have to double their current review staff. State budget problems could prevent many states from acquiring the needed staff.
- We have concerns about developing a national error rate based on states' prior cycle year error rates and that this may negatively impact the national error rate.

<u>Universe Definitions</u>

- Throughout the proposed rule, the claims universe is defined as "all adjudicated FFS and managed care (MC) claims information, on a quarterly basis, from the review year." However, the 2008 PERM Universe Data Submission Instructions expands that definition to include "essentially all of your state's Medicaid and CHIP beneficiary-specific payments." We ask that you clarify this instruction since there are many beneficiary-specific payments that are neither adjudicated FFS or managed care claims. It appears that the intent is to include more specific descriptions in separate instructions at the beginning of each PERM cycle. However, this discrepancy in the Data Submission Instructions changes the meaning of a "claim" as defined in the Rule and appears to go beyond clarifying instructions.

<u>Stratification</u>

- In some states the universe for the data is found in different systems, such as MMIS holds all active beneficiaries but does not give an indication of whether during the sample month a case was approved or renewed. Therefore, the approval and redetermination stratum had to be pulled from the eligibility determination systems which in some states are more than one system. Then the other strata are pulled from MMIS. A match has to be done to delete from the other strata those cases which fell into stratums one or two (approvals or redeterminations). If the information is not a complete match, some of the cases which should not have fallen into the other strata were not deleted, causing the case to be in more than one stratum. For this reason it was necessary to over

sample for the other strata. Almost one third of the cases needed to be replaced each month because of this issue.

- Eligibility stratification more than the actual size of the eligibility sample was difficult for many states. We suggest removing the requirement to stratify the eligibility sample. Since the requirement is to review the last action taken, if the sample is pulled from all active beneficiaries in MMIS, the last action would be either an approval or redetermination. With the requirement to stratify we pulled approvals, redeterminations and other. The other was then broken down based on last action to approvals or redeterminations. The stratification looks like a complicated way to obtain the same information.
- Stratification causes an additional burden on the states and causes problems with harmonizing with MEQC. The recommendation is to eliminate stratification.
- This section specifies the PERM active case universe (total number of Medicaid or CHIP cases), sample unit (individual or family) and sample size (minimum = not specified; base year = 504; maximum = 1,000) but mentions nothing about eligibility component stratification.
- We suggest adding eligibility component language alerting states to the option for two strata: Stratum 1 = active cases and Stratum 2 = negative cases.
- Language should also be added to clearly give states a way to modify the negative case sample size.

<u>Error Criteria</u>

- The new eligibility errors “Liability Overstated” and “Liability Understated” need further clarification. The description of “paid too much/too little toward his liability amount or cost of institutional care implies that only errors in the calculations of Medicaid patient liabilities are reported as errors. Please clarify if miscalculated medical co-pays or premiums are also reported as errors. If so, what amount is counted in error, the difference between what was paid and the correct amount or the entire payment?
- We suggest you increase the tolerance level for cost share liability errors to more than $25, to factor in caseload growth and inflation over the past 30 years. In other quality control programs there is a set tolerance for a certain percentage of cases that cannot be finished for one reason or another. Why doesn’t PERM have a set tolerance level?

<u>Undetermined Cases</u>

- States have concerns regarding the section of the proposed rule for how an undetermined case will affect the error rate. The proposed rule states that the undetermined cases will not be counted in the State error rate but would be counted in the National Error Rate. While we are happy they will not be counted in the State error rate we wonder what the rationale is behind counting it in the National Error Rate.
- PERM regulations require states to go beyond what is required of applicants for Medicaid. For example, some states do not require verification of household composition in determining eligibility for Medicaid. Yet, PERM regulations require verification, so in most cases additional contact is necessary with these

households. If they fail to respond to the contact, many of these cases end up undetermined. In most cases, household composition was not questionable. By including undetermined cases in the payment error rate, CMS results are not accurate. If CMS is concerned that states will place cases in the undetermined category to avoid errors, CMS has the option of reviewing state determinations. A contractor for CMS could review all cases coded undetermined to makes sure states are following the PERM guidelines. In the requirements for a CAP, states would also have to include a corrective action for something that is not an issue according to policy.

- What is the rationale behind the determination of two different error rates for undetermined cases? If the undetermined cases will be excluded from the individual state error rates, what purpose will be served by including them in the national error rate which may be potentially greater with this proposed inclusion? Allowing each state to function independently under state rules for error determinations, then lumping those error rates together nationally does not appear to provide any direct benefits to the eligibility study.
- Will there be a distinction made between undetermined cases where the information was not provided and for those instances where cases were undetermined based on insufficient documentation? Or will these undetermined errors be combined together in the national error rate?

<u>Provider versus State Errors</u>

- CHIPRA requires that the new PERM Rule include "clearly defined criteria for errors for both States and providers". The proposed rule does not amend current administrative criteria - it simply divides the current errors into state and provider errors, then combines and calculates the error rate using both categories. The criteria remain the same and the error calculation remains the same. Section 431.960 includes language that states "The Medicaid and CHIP state error rates include but are not limited to the errors described in paragraphs (b) through (d) (1) (iii) of this section. We do not believe that this meets the intent of "clearly defined criteria"?
- We recommend that two state error rates be provided to states – the state error rate and the provider error rate. That way states have the ability to report this information to the State Legislature and provider organizations.
- For eligibility the undetermined cases were cited as such and not counted against the state error rate. In the Medical reviews the MR1's are basically the same. The correctness of the medical need was not able to be determined without medical records from the providers. These cases should be considered undetermined and should not count against the State error rate.

<u>Self Declaration of Eligibility</u>

- CHIPRA clearly and plainly excludes errors related to self-declaration items as long as the state is in compliance with its approved processes. The proposed rule does exclude errors related to self-declaration from the error calculations. However, the proposed rule changes the eligibility procedures to require that the PERM audits gather data from independent sources, and that contradicts the states

self-declaration process. This conflict appears to be contradictory to CHIPRA. Further complicating matters it appears these procedures are different than the procedures in the past, resulting in inconsistent error rates from one year to another.

- Regarding self-declaration of application eligibility information, we would recommend that CMS not require any additional signatures or verifications for those state programs allowing self-declaration, beyond what is considered in compliance with the state policies and the approved State Plan, in effect at the time of the eligibility determination. Requiring a signature many months after the fact seems illogical and increases the likelihood of undetermined cases. By allowing third party verification, further issues are created when conflicting information is obtained as well as dramatically increasing costs to state to conduct such verification. Requiring the signature and/or implementing third party verification also undermines the systems and processes that have been implemented to promote simplification of application process for uninsured children.
- The proposed rule states "However, we are proposing to specify in the new section 431.960 that these errors be tracked nationally by including these undetermined cases in the national program payment error rates." This section pertains to self-declared eligibility information that, if ultimately not valid/current in relation to the review month, will result in a finding of undetermined and counted in the national program payment error rates. Unverified self-declared eligibility information "errors" should not be included in the national payment error rates. Instead, defer evaluating these findings until provisions for the express lane eligibility option is developed. Both are products of the effort to simplify eligibility processing.
- Citizenship information is generally documented just once and therefore may be more than 12 months old. The proposed rule indicates the self-declaration statement must not be outdated (more than 12 months old).
- Will it be acceptable to verify citizenship via self-declaration? The practice of not factoring "undetermined" cases into the state-specific error rate brings the PERM error rate calculation procedure more into line with other Federal program review practices. Is there a maximum threshold of "undetermined" findings for the monthly/annual PERM sample? Will there be a completion rate adjustment in the final PERM state-specific or national error rate?

Difference Resolution and Appeals Process

- There are new requirements that allow for an appeal process for error cases. The appeal may be generated by the agency responsible for eligibility determinations (in this state's situation it is the county) similar to the MEQC appeal error process. This is a change to the prior requirements as no appeal process was in operation. In each of the cases with error findings from the FFY 2007 PERM, the analyst reviewed the finding in detail with the respective county and worked with the county liaison to mitigate the error finding. A new process would be required to implement an error finding process similar to MEQC. This activity

will create a workload that can be absorbed by current staff but will impact completion of the monthly sample when error cases are identified.

- Based upon the intent of the proposed regulations, please clarify which entity within the state should render a final decision on disputed findings. Should the state Medicaid or CHIP agency or the independent state agency conducting the reviews have final authority? Or should the resolution responsibility be independent of both agencies? Will reporting of the dispute and resolution to the oversight contractor be required?

Harmonization of MEQC and PERM

- CHIPRA clearly and plainly requires CMS to harmonize MEQC and PERM to reduce the burden on the states. The proposed rule attempts to allow for substitution of results from one review for another, however, the proposed rule falls short of harmonizing the two programs. The rule continues to have differences in sample size, sample methods/stratification, review procedures, error calculations, and other significant differences. CMS should modify the rule to truly harmonize these two programs.
- The proposed rule does not accomplish much toward the "harmonization" of the MEQC and PERM processes unless states are willing to switch to the traditional MEQC approach. We don't believe many states will switch to the traditional MEQC program because of the possibility of fiscal sanctions associated with traditional MEQC programs should the state's error rate exceed 3%.
- The proposed rule allows states to use the same sample for PERM and MEQC, but MEQC and PERM continue to require separate redundant review processes. MEQC pilot states are not allowed to use the same sample for PERM and MEQC.
- CMS proposes that states doing pilots have no options and must continue the pilots and do PERM. The 2010 states should be allowed the option to discontinue a pilot or put it on hold until FFY 2011 because there was not time to plan for pilot versus harmonizing options.

In response to your request for substitution of PERM OR MEQC data we offer the following comments:

- The definition of eligibility errors include "…an error resulting from services being provided to an individual who had a lack of or insufficient documentation in the case record to make a definitive determination of eligibility or ineligibility." We **strongly** disagree that these are errors to be included in the state specific error rate. Some documents may not be in the physical case file for a variety of legitimate reasons and no longer obtainable. Some clients may refuse to furnish information critical to the review determination. To cite eligibility errors in these situations is inappropriate, especially if the individual is eligible but the agency's filing system is malfunctioning. This may be a deal breaker for the MEQC/PERM substitution effort. Per State Medical Manual Section 7230, "Beneficiary Does Not Cooperate.--Drop the review due to lack of cooperation by the beneficiary only after all efforts have failed and you have notified the local agency that the beneficiary did not assist in substantiating his/her eligibility status. Also, if a beneficiary is uncooperative when approached by the reviewer, obtain assistance

from the local agency and/or send a second reviewer to attempt to complete the review.

- To implement the option to use PERM for MEQC (or MEQC for PERM) one state would have to give up the current pilot which limits MEQC to the 25 largest Medicaid population counties with minimal reviews in the remaining 33 and again review a sample from all 58 counties. In addition, the MEQC sample would have to include all federally funded aid codes where under the current pilot the state does not include those aid codes with less than 2,500 persons statewide. Since pilot states' MEQC error rates are frozen, they are effectively sanction-free for MEQC purposes. The sanction-free status and additional MEQC flexibility is much more valuable than using combined MEQC and PERM results. For non-pilot states, this concept may provide desirable flexibility. For a pilot state, this is not recommended at this time.
- For the PERM/MEQC substitution, the opportunity must be considered against the overall net result for the state in terms of expenditure savings, accuracy requirements, independence of the PERM process, and disallowances/reimbursement for erroneous payments.
- For one state currently operating a MEQC pilot program, exploration has begun to look at options by which the coordination of MEQC and PERM can be accomplished. While section 431.812 allows states performing traditional reviews to substitute to MEQC reviews for PERM in the same year, those states conducting pilot programs are prohibited from doing so, creating an inequity of expectation. Excluding pilot states from performing the allowed substitution, continues to require the same duplication of effort for eligibility reviews within the same year. Particularly since MEQC reviews do not address the CHIP population.
- Either all states will have to revert to traditional reviews or restructure their eligibility review programs to encompass both the Medicaid and CHIP population, which may negate any potential or possible savings based on a reduction of redundancy. This is especially true for those states that use separate entities to perform CHIP eligibility reviews versus Medicaid reviews. States will still have to implement some program to capture the overlooked CHIP enrollees. However, since pilot states will be able to substitute PERM negative case reviews to meet the negative MEQC requirements for Medicaid reviews, some semblance of savings may occur.
- The proposed Rule seems to be saying that in the substitution of PERM for MEQC, each case will be reviewed by both MEQC methodology and PERM methodology. Taken as literally as it has been presented means a review, as of the review date, with an interview and field investigation as of that point in time. While at the same time the reviewer would also be looking at the most recent action and attempting to determine whether the case was correct as of that date according to the PERM review standards. Is the intent to produce two error rates, one at the lower bound for MEQC and one at the point estimate for PERM?
- The IPIA requires dollar error rate estimates at the national level and could be satisfied by an intact, statistically valid MEQC. PERM comes closer to meeting

the MEQC statutory requirement than any of the pilots being allowed by CMS. This would represent a 100% elimination of redundancy as well as avoid the confusion that appears to be coming with the “harmonizing” proposals.

- The opportunity for PERM/MEQC substitution must be considered against the overall new result for the state in terms of expenditure savings, accuracy requirements, independence of the PERM process, and disallowances/reimbursement for erroneous payments.

Definition of a Case

- Regarding the proposed rule change for the definition of a case from individual to individual or family - would states have the option of either using the traditional definition of case used by MEQC or setting up the universe by individual as the PERM regulation required in the past?
- The regulations need to be clear on how the universe is to be set up and sampling accomplished.
- Reviews completed at the case level rather than the individual level would require more time to complete, causing staffing issues for states.
- For the 2007 cycle year, a case was considered to be a single individual. Under these regulations the case would be all persons meeting the PERM requirements. The justification for this change was that many states expressed difficulty in sampling at the individual beneficiary level. Since our state did not have this problem, this change will have a workload impact as gathering data for the eligibility review for all persons will increase the time needed to document findings. In addition, a workload increase will occur for the fiscal data for paid claims and managed care payments for these additional persons. The current average of persons per case is 2.5. The change from cases comprised of families instead of individuals will inherently increase opportunities for errors (e.g., simply because of having more beneficiaries to review and the additional possibilities of “eligible beneficiaries” with ineligible family members). Thus, in fairness, if this concept is implemented, error thresholds should increase commensurately.

Corrective Action Plans (CAP)

CAP Timeline

- The five steps for CAPs are very similar to those applied to the Medicare Comprehensive Error Rate Testing (CERT). State error rates are usually posted no later than November 15th. States may have to start the required steps earlier in the PERM cycle, which could add to workload and cost. The 60 day timeline for developing and submitting corrective action plans to CMS seems too short based on the requirements and the time of year.
- The outline of CAP requirements in the proposed Rule will involve a significant amount of staff time and, for some states, collaboration across organizations. Therefore, we recommend the timeline for submission of CAPS be extended to 90 calendar days rather than the proposed 60 days.

- The timeframe to complete a comprehensive CAP is too short, especially for errors identified during the last few weeks of the PERM review cycle and because of the onerous corrective action process being added to regulation. We recommend CMS ask for a preliminary CAP 60 days after the error rate is posted with an additional 60 days to finalize the plan.
- Propose the idea of a threshold for the implementation of a CAP. If the error rate for claims or eligibility is below that threshold, it should be optional for the state to create a CAP for the applicable section.

CAP Development

- We are committed to utilizing PERM findings as a management tool to improve Medicaid and CHIP program administration. However, we are concerned the process in its proposed form may generate questionable findings. The process openly sidesteps the specter of client errors or their implication, gives undetermined cases equal weight as not eligible findings, and ignores elements of the federal documentation/review contractor procedures that can impact state findings.
- The proposed rule provides a general outline of what should be considered when drafting a CAP but does not offer guidance regarding the expectations of the components of a plan or provide for technical assistance in preparing a plan. In some cases, error rates have been calculated according to all information received by CMS prior to the deadline. Are states able to consider receipt of additional information after the deadline when drafting a CAP?
- Since the proposed regulation calls for such an intense data and program analysis, system and program corrections should fully correct the errors discovered from PERM reviews and states may realize cost savings from correcting these payment errors. However, thorough data and program analysis is time intensive and a drain on staff resources. The main difficulty with this comprehensive process being added to the Rule is that it doesn't give the states flexibility to tailor the extent of the program and system analysis based on staffing and other resources.
- The notice states "The corrective action process involves analyzing findings from the PERM measurement, identifying root causes of errors and developing corrective actions designed to reduce major error causes, and trends in errors or other factors for purposes of reducing improper payments." The start of this sentence implies that the CAP is specific to PERM reviews. However, the last part of it identifies 'other factors for purposes of reducing improper payments'. It is unclear what is meant by 'other factors' and whether it means things such as audit findings from separate OIG reviews that are not PERM related. Please clarify the extent and meaning of the 'other factors' as it relates to PERM review errors and the CAPs associated to them.

CAP Review and Evaluation Process

- We have great concerns about the requirements for monitoring and follow up of the CAP. The Evaluation section references updates requiring "concrete data", which suggests states will have to research and maybe even conduct new

reviews to evaluate outcomes to these specifications. Please clarify the expectation for "concrete data". The overlapping of PERM cycle CAP activities along with the frequency of the monitoring requirements for "regular updates" could be time-consuming for state staff. Any processing errors that identify systems problems may take months to correct depending upon the criticality. Policy updates and provider training also take time to plan and complete. Corrective actions will most often bring long-term results. Once a CAP is initiated, states should not be undergoing update requests for data analysis early in the process, as it will not be productive.

- The proposed Rule indicates states are responsible for all the analysis work to develop the CAP. Based on this, CMS would apparently have no detailed knowledge of the issues that drove the development of the plan. It is not clear on what basis they would therefore be making their approval decision. There also is no indication of what happens if CMS does not approve the plan and the state disagrees with that decision.

Recoupment of Claims

- The proposed Rule does not address requirements related to recoupment of claims identified as errors. We recommend adding specific guidance regarding CMS expectations of what states can and should recoup from providers whose payments have been determined to be in error, plus regulatory authority for the recoupment of the payment when an error is found as the result of PERM activities.
- The proposed regulations associated with CAPs do not address states with provider appeals processes. States can be unduly penalized if the provider wins the case at appeal.

Miscellaneous Comments

Reinstatement of CHIP Reviews

- Although not specifically spelled out in the NPRM, reinstatement of CHIP reviews remains questionable for states. States suspended CHIP reviews as instructed by CMS. It appears that reinstatement of CHIP is imminent which will be problematic. If and when CMS reinstates CHIP reviews, will CMS provide detailed guidance for those eligibility reviews? The current review cycle for the FFY 2009 PERM will need to be modified and revised, if that is the case. Will the reinstatement be retroactive to April 2009 reviews or begin with the sample month coinciding with reinstatement—that is if the reinstatement occurs prior to the fiscal year end? Many states have had to address state budget deficits that severely impacted some state functions. For this reason alone, reinstatement of the full review schedule will be problematic for states already limited by budget constraints.
- How will the reinstatement of CHIP reviews affect the eligibility error rates? If states are allowed to present less than a full year of eligibility data for CHIP, how will the lack of eligibility data be factored into the state and national error rates?
- Since states stopped doing Title XXI (CHIP) cases while awaiting the revised final Rule. FFY 2009 states will need to complete a total of 504 cases for CHIP

in order to satisfy the requirement for a "base year determination". How would that impact future sample size requirements? Requiring states to complete 504 active CHIP reviews and 204 negative CHIP reviews for FFY 2009 would result in staffing issues for many states. States do not have the staff needed to complete that number of reviews.

60 Day Adjustment Timeframe

- States are concerned that current claim audit procedures will only consider claim adjustments made within 60 days of the date of service. State policy generally allows for a greater timeframe for submission of payment adjustments and CMS should consider claim adjustments according to state policy.

Contractor Quality Assurance and Process Improvements

- What quality assurance process is envisioned to ensure the work performed by the contractor is accurate?
- Will the contractor be required to persistently attempt to secure the information requested from providers? States have found that in some cases it has taken several attempts before the requested information is submitted.
- The following comments address issues not in the regulations themselves but more the process CMS or their contractors utilize:
  - The Documentation and Database Contractor (DDC) should request medical records (initial, second, third and final) on the same day for each state, quarter and program. Currently, the schedule is staggered because the initial requests are made over a several week span. As a result, states end up having to log-on daily or create their own separate tracking system if they want to effectively track provider compliance and/or time remaining to the final due date for a particular claim.
  - The DDC should include the state Claim ID on the record request form sent to the providers and on the status charts made available to states. This will allow states to be able to efficiently track progress and answer questions received by the providers. This will also provide states with the ability to crosswalk from the DDC charts to the RC charts without have to do any additional lookups.
  - In addition to totaling the information on the DP Sampling Unit Disposition Reports by program (i.e., Medicaid and SCHIP), the RC should also provide subtotals for each program category (i.e., Managed Care and Fee-For-Service) within each program. If the universe data needs to be provided by states separately to be reviewed as distinct review categories, it should be reported by the federal contractors the same way. This is extremely important to states that have responsibilities split depending on programs and program categories. When response times are short, it is critical to be able to forward information quickly without having to download the information and manually manipulate it each time the data is updated.

Medical Terminology

- PERM Rules are built around language related to “medical services”, “medical documentation” and “medical review” including “medical necessity”. There are a variety of Title XIX services that do not fit within the medical review model.

- The PERM Rule and related materials reference the medical model. This is very confusing for providers who do not generate “medical” documentation during the course of their business. Clarify in the PERM Rule the variety of services that are included in the review. Related materials, including PERM letters to providers, must also be clarified to reflect the variety of services that are provided by the entire scope of Title XIX payments.
- Change the terminology from “medical record review” to “medical and service record review”, including revision of communication to providers around the use of the word “claim” to include “payment”.

Federal Funding

- Section 601 of the CHIPRA provides for 90% Federal match for CHIP spending related to PERM. There is no similar provision to support Title XIX PERM reviews. To achieve parity between the Title XIX and Title XXI PERM Rules, CMS should provide enhanced federal funding for state resources to support all PERM reviews.

National versus State Auditing and Reporting

- Any exclusion applied to state-specific error rate should also be applied to the national error rate (e.g., errors resulting from self-declarations).
- Give states the option to conduct, in whole or in part, its own data processing and/or medical reviews. Similar to the eligibility reviews, these reviews could be conducted by contract staff or staff that is separate from policy staff. For some programs (i.e., Medicaid and CHIP) or program categories (i.e., Managed Care and Fee-For-Service), the amount of time spent meeting with the RC to bring them up to speed far exceeds the amount of time spent conducting the actual reviews.

State Cost Estimates

- The estimate of annualized costs breaks down to $181,071 per state per program per year. This estimate is not feasible for one state based upon their estimates from the FFY 2007 PERM of 6,373.4 total estimated hours X $54.87/hour for a total of $349,708.458. This estimate will increase for the FFY 2010 PERM cycle.

Enclosed please find additional technical comments that should be considered as comments to this proposed rule.

While you work to finalize this rule we believe you need to think about the overlap between PERM and Program Integrity in addition to the MEQC and PERM harmonization. Especially during this time of financial constraint for the states we feel that it is crucial for you to review all these error review programs and harmonize them with one another as much as possible. We appreciate the renewed effort of CMS to work with the states on these issues and continue to believe that CMS can take additional steps to assist states attempting to comply with the PERM project. We are eager to continue working with you on this and other issues and appreciate your time and consideration of

these comments. Should you have any questions please contact me at 202-682-0100 x299.

Sincerely,

Ann Clemency Kohler
NASMD Director

Cc: Cindy Mann