Information Collection Package (ICP) Notice
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Responses to Comments from the 60-day Comment Period

We received comments from 14 entities on the ICP notice announcing CMS' plans to have States implement the eligibility reviews for the Improper Payments Information Act (IPIA) of 2002 in Medicaid and the State Children's Health Insurance Program (SCHIP).

General

Comment: Several commenters were pleased with CMS allowing states the option to substitute Medicaid Eligibility Quality Control (MEQC) reviews and SCHIP program integrity requirements for Payment Error Rate Measurement (PERM) eligibility reviews and had specific comments/questions regarding the application of this option, including:

- If a state opts to perform traditional MEQC to meet the PERM eligibility requirement will MEQC penalties apply to PERM?
- The state's most recently reported error rate should be "frozen" as meeting MEQC requirements while states' MEQC staff performs PERM reviews.
- What are the conditions in which CMS will allow traditional MEQC reviews or SCHIP program integrity requirements to substitute for or satisfy the requirements of PERM eligibility reviews?
- There is insufficient detail explaining the allow-ability of "pilot" MEQC reviews to satisfy the requirements for PERM eligibility reviews. This commenter request that pilot states be allowed the flexibility to conduct a "traditional" project for the purpose of PERM.
- Will states be allowed to return to pilot status when their year of PERM reviews is over?
- The methodology and transition issues for states to asses the value of this option were absent from CMS' latest notice, e.g. the steps entailed in the conversion from traditional to pilot, etc.
- One commenter pointed out that the use of the PERM sampling plan to perform MEQC reviews may not satisfy both programs because PERM review requirements are different from MEQC or SCHIP quality control requirements.
- Will the substitution option apply to negatives as well as positive case reviews?

- PERM should be an approved pilot under MEQC. MEQC staff should be used to perform PERM reviews.

Response: We proposed the option to use the MEQC reviews to satisfy the PERM requirements in the first publication of this information request. We also considered the option to use the PERM reviews to satisfy the MEQC requirements. However, the PERM program is intended to fulfill the requirements of IPIA and is not intended to supplant, enhance or change other program integrity activities in which the States are currently engaged. We are considering methods to minimize duplication of efforts regarding the eligibility reviews.
Comment: There were several questions regarding the composition and other details regarding the eligibility workgroup. Each commenter suggested that CMS should make the eligibility workgroup's recommendations available to the public.

Response: We are responding to comments regarding the cost and burden associated with the eligibility reviews . As such, this comment is not germane to the eligibility collection or the related cost and burden estimates.

Comment: Will CMS waive the SCHIP provision that only allows for a 10 percent cap on administrative expenses during the year when a state does its SCHIP PERM review? The cap is likely to impede a state's ability to fully comply with PERM and/or SCHIP regulations.

Response: States will be compensated at the SCHIP match rate, similar to other Federal audits. We are not considering exempting the costs of PERM-related activities from the 10 percent cap on SCHIP administrative expenditures.

Comment: There are no provisions for the state reviewing the federal contractor's finding regarding the SCHIP cases.

Response: The states, not the federal contractor, will be conducting their own SCHIP eligibility reviews.

Comment: What will be the process for the federal contractor to request medical records? The federal contractor should be required to make several requests to the providers as the states do.

Response: The federal contractors will not be requesting medical records for the eligibility reviews. The medical records request is to support the medical review of fee-for-service claims by

the federal contractor. The contractor will make several contactors with providers to obtain the medical records within 90 days of the initial request.

Comment: One commenter was pleased that CMS intends to allow states to electronically submit information if the state has the technological capability and secure systems in place. Model practices, including the Food and Nutrition Service's providing the software and connectivity to their web sites for data edit checks, transmission and confirmation of data received for their programs.

Response: CMS does not expect that the data gathering will extend beyond those in this notice and on these draft forms. Therefore, standard programs such as Microsoft Excel, Access, etc. will be sufficient to gather and report to satisfy these requirements.

Comment: A few commenters requested that CMS provide information regarding the intersection of PERM and other programs that have a fraud and abuse component including the new Medicaid Integrity Program (MIP).

Response: PERM measures improper payments based on medical necessity, data processing and eligibility. As such, PERM does not identify fraud and abuse and would not intersect with these programs. As stated above, the PERM program is intended to fulfill the requirements of IPIA and is not intended to supplant, enhance or change other program integrity activities in which the States are currently engaged.

Comment: Denied and terminated cases do not allow for the payment of Medicaid services and therefore, do not meet the purposes of PERM.

Response: IPIA requires measurement of payments that should have been made and therefore, negative case actions could be considered payment errors. We have proposed to calculate only a case error rate for these cases so States will not incur administrative burden to estimate underpayment amounts for services that should have been provided to the sampled cases.

Standard Methodology

Comment: A commenter noted that the documentation required to substantiate eligibility was not included in the notice and that

“facts” be equated with caseworker notes recorded during the review be acceptable.

Response: CMS is finalizing the eligibility plan and will issue instructions as to the detailed aspects of the reviews.

Comment: A number of commenters cited that given the lack of detail regarding the eligibility component of PERM, it was difficult to fully evaluate the burden and believe the stated estimates are underestimated. One commenter noted that it is difficult to comment on the data collection requirement when CMS uses the phrase “standardized review methodology” and doesn’t supply the document. Will states be able to comment on the proposed methodology? When will it be released? Will there be flexibility with the review methodology?

Response: CMS will provide detailed instructions regarding the standard review methodology. The review methodology will be flexible to the extent that each state’s programs and policies are different. The interim final rule was published on August 28, 2006 (71FR51050) and invites further comment on the eligibility process.

Comment: Commenters recommended that an administrative period be allowed that no errors based on a change in circumstance in the review month or month prior to the review month be cited. A commenter pointed out that “States will conduct reviews in accordance with the State’s eligibility policies that are in effect as of the review month” and the absence of an administrative period as being contradictory.

Another commenter pointed out that if the eligibility action being reviewed is several months earlier and in error at time of application, an interim event could have occurred that corrected the error. Will the interim event be taken into consideration if claims are being collected for the sample month?

Response: We are finalizing the eligibility plan and will issue instructions as to the detailed aspects of the reviews. In our effort to provide States with instructions as quickly in advance as possible, we are not able to anticipate and address every scenario and policy issue in these instructions. However, we intend to enhance the guidance as the reviews progress to address issues such as those pointed out by the commenters.

Comment: A commenter suggested having eligibility review flowcharts.

Response: The eligibility instructions will include exhibits, flowcharts and other helpful tools.

Comment: SCHIP eligibility review requirements in 42 CFR 457, subpart I, requires states simply to establish procedures to ensure that enrollees make timely and accurate reports of changes that may affect eligibility and to promptly redetermine eligibility when the state has information about these changes. This commenter recommends that guidelines for SCHIP eligibility reviews would provide greater consistency among states.

Response: 42 CFR 457.965 states that there must be facts to support the state's determination of eligibility for SCHIP. Because each state has designed its own program within federal guidelines, each state will be measured against its own standards.

Comment: Define "undetermined".

Response: An undetermined case is when eligibility cannot be verified from a review of the case record and/or through independently obtained documentation or outside sources such as employers and efforts to contact the beneficiary have failed.

Comment: Please clarify how unobtainable information will be factored into the error rate, including information not received by the client or eligibility worker.

Response: We expect that given the stratification of cases, the chances of unobtainable information will be small. However, if eligibility cannot be verified the case will be classified as "undetermined". Undetermined cases are not factored into the payment error rate. The undetermined cases and payment amount will be reported by the States and tracked by CMS.

Comment: The ability to cite cases as undetermined seems to be contradictory to section B item two where it states, "to ensure the States complete reviews on all cases sampled."

Response: CMS wants to ensure that states follow through, with due diligence, each case review. Therefore, cases where eligibility cannot be verified will not be dropped from review and replaced but will be reported as undetermined along with the payment amounts. These cases will be tracked by CMS.

Comment: One commenter said states used specific definitions/categories of “recipient error” and asked CMS whether or not the same definitions/categories will be employed in PERM going forward.

Response: States will verify eligibility against their own standards/policies. The national implementation of PERM will consider all errors, even those perpetrated by the beneficiary to be an error. The causes of errors, if known, shall be recorded but the full payment in error amount will be calculated into the eligibility error rate.

Comment: One commenter requested that CMS clarify how States should handle cases that are not subject to review or cannot be completed due to non-cooperation of recipient or collateral contact.

Response: All cases are subject to review unless specifically excluded from the universe. Cases where eligibility cannot be verified will be reported as undetermined.

Comment: One commenter requested that CMS consider the “undetermined” designation for negative case reviews. The commenter cited the difficulty in obtaining information from applicants and beneficiaries who were denied or terminated.

Response: The PERM negative action review is desk review. If the case file record does not have sufficient information to support the negative action, then it will be cited as incorrect. Incorrect negative case actions will not have dollars associated or produce a payment error rate.

Comment: One commenter asked CMS to clarify the length of time that States will be permitted to obtain claims information. How will CMS treat cases where no bills are paid for the review month?

Response: We expect States will wait until 5 months after the sample month to collect claims for services received within the first 30 days of eligibility, the review month or the sample month and paid within four months. All active cases are included in the payment error rate calculation even if no payments were made during that timeframe.

Comment: One commenter requested that persons ineligible for SCHIP because they are eligible for Medicaid not be considered

totally ineligible and the true error only the difference in rate of federal financial participation between the programs.

Response: Medicaid and SCHIP are different programs funded from different authorities and funding streams. OMB has determined that each should have its own error rate. Therefore, we are measuring each program separately.

Comment: Payments/adjustments for services are made before, during and after the first 30 days of eligibility or the sample month and an accurate payment error cannot be produced.

Response: States will collect claims for services received in the first 30 days of eligibility, the sample month or the review month, as appropriate. States will wait until 5 months have passed before beginning to collect the claims. A 60-day adjustment period will apply to claims collected on the eligibility measurement, similar to the fee-for-service and managed care claims measurement.

Eligibility Reviews Timing

Comment: Several commenters recommended that CMS not measure eligibility simultaneously as the fee-for-service and managed care measurement due to the increased level of effort in a state to participate in all three component's measurements. Another commenter stated it was their understanding that under PERM, if the medical or data processing review revealed an error, then the eligibility portion did not need to be reviewed for this case since an error was already discovered. Others asked similar questions regarding whether a separate sample needed to be drawn or if the eligibility review could be done on the samples being drawn by the federal contractors.

Response: The PAM and PERM pilots established that verifying eligibility on the date of service on a claim was excessively burdensome and that a random sample of cases, reviewed for the same fiscal year as fee-for-service and managed care claims could produce an error rate that could be merged with the fee-for-service and managed care components. While these component error rates are independent of each other, using statistical probabilities and assumptions, the statistical contractor will derive one programmatic error rate.

Comment: Operating Medicaid and SCHIP reviews in the same year will be burdensome. A few commenters suggests that CMS not require a separate sample for eligibility reviews as the states

and the federal government, through the national contractor, have devoted a significant amount of resources to drawing the claims sample. The integrating of the eligibility review with the claims review would eliminate the need for states to submit an eligibility sampling plan, selecting monthly samples, submitting monthly sample lists, attaching payment and conducting negative reviews. Another commenter asked how states selected for FY 2006 will be impacted by the eligibility reviews. Another commenter suggested that a third of the number of cases be sampled each year in a three year cycle.

Response: The sample size of cases to be reviewed will be determined by the confidence and precision requirements of IPIA. CMS believes that States should conduct Medicaid and SCHIP reviews in the same fiscal year in an effort to reduce administrative complexities, and gain efficiencies by combining staff and resources for both reviews. Each program will be measured separately and only once, every three years. Those States selected for the FY 2006 measurement will not be participating in the Medicaid and SCHIP eligibility reviews again until FY 2009.

Comment: Will the eligibility reviews begin in FY 2007 as indicated in the October 5, 2005 interim final rule?

Response: We expect the eligibility reviews will begin in FY 2007 as we indicated in the October 5, 2005 interim final rule.
Comment: CMS should produce a timeline and schedule for Medicaid and SCHIP reviews and deliverables so that States can be more prepared.

Response: CMS will be including these items in the instructions we expect will be released in the fall.

Error Rates
Comment: Several commenters raised concerns about a state specific error rate and fiscal penalties that may be conferred upon states when IPIA only requires that CMS produce a national error rate. Will there be any penalties or procedures for disallowances under PERM? One commenter inquired how a national error rate will be calculated if states are selected on a rotating basis.

Response: The State specific error rates, from the 17 states, will be used as the basis for a national programmatic error rate each year. The PERM program does not change the current statutory provisions regarding recovery and or penalties or add new

requirements. The statutory provisions requiring recoveries of misspent Federal funds due to Medicaid eligibility errors are at section 1903(u) of the Act. The general recovery provisions for misspent Medicaid Federal funds other than those due to eligibility errors are at section 1903(d) of the Act. For SCHIP, the recovery provisions are at section 2105(e) of the Act.

Comment: A commenter asked whether PERM reviews will include findings and if so, how CMS or others will utilize these findings.

Response: The data collection package included draft forms of the information being collected by CMS. Error findings will be used by States to develop corrective action plans.

Comment: A commenter asked for the formula States will use to calculate the State-specific eligibility error rate based on the review results and payment errors.

Response: CMS will provide the formula for the error rate calculation in the upcoming instructions.

Comment: PERM eligibility reviews should allow for at least a $12 payment error tolerance threshold.

Response: We do not agree with this comment. The IPIA and subsequent OMB guidance does not provide for a payment error tolerance threshold.

Comment: One commenter recommended that undetermined cases not be included in the error rate nor cost-recovery efforts taken.

Response: Undetermined cases will not be included in the improper payment error rate at this time. Since these payments have not been determined to be in error, we do not believe the current recovery provisions would apply.

Comment: Please clarify the manner in which states will be required to calculate the eligibility error rate. Will the case error rate associated with incorrect denials and terminations be combined with the case error rate for active cases, or will they be reported separately? How will the negative rate be factored into the total error rate? Will the error rate calculated for claims and medical processing reviews be somehow combined with the error rate associated with eligibility to derive one overall payment error rate per State?

Response: Each state will calculate three error rates per program, an active case error rate, a negative case error rate,

and an active case payment error rate. States will also report the number and percentage of undetermined cases and dollar amounts. The claims and medical processing reviews will be combined with the error rate associated with eligibility to derive one overall payment error rate per State. The federal contractor will calculate national eligibility error rates for Medicaid and SCHIP based on the States' error rates.

Comment: Are the payment amounts of undetermined cases included in the error rate denominator?

Response: The undetermined cases payment amounts are in the denominator of the payment error rate.

Comment: Does the 5% assumption denote case errors or payment errors?

Response: The 5% assumption is for a payment error rate for the active cases .

Cost and Burden

Comment: Several commenters believe that CMS has not taken into account all of the potential costs in the burden estimate, e.g. the costs to hire and train new staff. One commenter provided an estimate of 17,500 hours.

Response: Generally, these estimates should not include burden hours for customary and usual business practices such as recruiting and hiring new staff. CMS derived these estimates using data collected regarding reviews as reported by states themselves during the PAM year 2 pilot. The hour burden on respondents is not expected to vary widely because there will be no differences in review activity or sample size. The 17,500 hour suggested estimate was not detailed and therefore was not compared to the CMS estimate.

Comment: A commenter stated it is arbitrary and unreasonable to calculate the total cost using the GS-12 salary as the base and CMS fringe and overhead rates as these figures will vary widely from state to state and suggested that a range be used.

Response: CMS estimated of annualized cost to respondents for the hour burdens for collections of information, identifying an average wage rate recognizing that even among the burden hour estimate the wage rate will vary within a state. The GS-12 wage was determined to be the estimated level of knowledge, skills and ability to perform this work.

Comment: Several commenters suggested CMS provide 100% federal reimbursement for the PERM program. Several commenters also suggested that the cost benefit analysis does not provide a positive return on investment.

Response: The States will be reimbursed for these activities at the applicable administrative Federal match under Medicaid and SCHIP. As part of the rulemaking process, we have evaluated and determined that the burden and cost of these responsibilities will not significantly impact the States. 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. Since we are estimating improper payments in a select number of states, primarily through a Federal contracting strategy, we believe the State cost to measure error rates has been substantially reduced. We anticipate that savings will be realized over time through States' corrective action measures, and modeling best practices.

Comment: A commenter suggested the 2,135 hours for supporting functions is not enough and that training of eligibility case reviewers alone would be in excess of 1,000 hours leaving supervision, coordination of re-reviews, creation of review tools, tracking programs, quality assurance, etc. One commenter suggested adding 800 hours for project coordination.

Response: If strata 1, 2 (14 cases from each stratum monthly) and negative cases (17 each month) take up to 10 hours to complete and stratum three takes up to 15 hours to complete, in any given month, there will be a total of 660 review hours. Our assumptions included that an FTE reviewer will be available to complete reviews for 158-173 hours per month. This results in approximately 4 FTEs.

Training 4 FTEs can be done classroom style and on-the-job. Therefore, CMS estimated approximately 5 FTEs (4 reviewers and a trainer) will conduct PERM reviews and that classroom training will be no longer than a week (5 X 40 hours plus 40 hours training prep time =240 hours). We further included the assumption that only experienced eligibility personnel will conduct the reviews. We further believe that due to the small review staff, one supervisory FTE is sufficient to perform training, quality assurance and all supporting and coordinating functions throughout the PERM eligibility review cycle. 158 monthly FTE hours over 12 months is 1,896 hours. 1,896 plus 240 hours is 2,136 hours. We consider 2,135 to be a rounding error.

Comment: A few commenters were concerned with the costs of conducting full eligibility reviews including in-person interviews. They felt it was unclear what the minimized verification requirements are and how they apply to the issue of face-to-face interviews. It was requested that CMS incorporate language to specify situations in which travel can be waived or that otherwise that eligibility for such cases can be considered "undetermined" and that the in person interview requirement be made only when accurate determination of eligibility necessitated such an interview. Other commenters requested CMS provide additional information about the proposed verification requirements.

Response: We expect that in person interviews will be optional. However, minimal attempts to contact the beneficiary by phone or letter are expected prior to citing the case as "undetermined".

Comment: The return on investment of the PERM reviews is small.

Response: The IPIA requires error rate measurement based on eligibility and does not cite lack of cost savings as a circumstance which would excuse us and the States from measuring improper payments. Since we are estimating improper payments in a select number of States every three years, we believe the State cost to measure error rates has been substantially reduced. We anticipate that savings will be realized over time through States' corrective action measures, and modeling best practices.

Comment: The stratification of the cases into applications, redeterminations and all other ongoing cases is a difficult programmatic change to one at least one State's eligibility system.

Response: We appreciate the challenges a State may face, however, we believe that identifying active and negative cases is a routine State activity and thereby selecting a sample for PERM can be planned and implemented in the 2,200 hours estimated in the development of the sampling plan (1,000 hours) and the generation of sample selection lists (1,200).

Comment: One commenter suggested CMS consider a performance bonus arrangement for the States that operate effective and efficient Medicaid and SCHIP programs like the Food Stamp program.

Response: This comment is not relevant to the eligibility collection and would not be a recommendation that would necessarily fall under the purview of the PERM program.

Comment: A few commenters requested significant time for States to respond to and amend their sampling plan.

Response: CMS has provided that sampling plans are due 60 days prior to the year being measured. Given that the error assumptions and sampling size are uniform for all States, we believe that the sampling plans will need little rework once submitted. Therefore 90 days (sampling commences the month following the first sampling month)for implementation is sufficient.

Sampling

Comment: Several commenters had questions regarding sample size development and its relationship with State programmatic population size.

Response: Specific sampling questions will be addressed in our instructions. We anticipate that for FY 2007, States sample size will be 504 active and 204 negative based upon a 5% assumed error rate.

Comment: A commenter requested the definition of "last action".

Response: "Last action" is defined as the most recent date on which the State agency took action to grant, deny, or terminate program benefits based on the State agency's eligibility determination; and is the point in time for the PERM eligibility reviews unless the last action occurred prior to 12 months prior to the sample month.

Comment: One commenter noted that sampling negative cases will be problematic for SCHIP as very few children are ineligible for one of the programs in their State. This commenter's SCHIP program offers a "buy-in" feature whereas the applicant is eligible for a State funded program when they do not qualify for a subsidized program.

Response: Should a SCHIP applicant be denied eligibility for SCHIP, 42 CFR 457.340 (e) (2) and 457.1180 regarding notice should apply and therefore we disagree that it will require additional State burden to include a process by which to identify these cases.

Comment: It would seem that a smaller sample size should be required for a small population State and the equal sample size

creates inequitable requirements and excessive burden in small States.

Response: The explanation for sample size is included in this revision. The sample size needed for a given level of precision is almost independent of the total population. The 500 sample size gives essentially the same sampling precision whether it is extracted from a population of 10,000 or an infinite population. Also, CMS has taken a finite population (smaller than 10,000 units) into consideration and will allow a State to explain why their sample size should be smaller.

Comment: Statistical validity need only be for the larger national sample. Small states could still have reasonable confidence in their findings with smaller samples.

Response: There is no national sample. We are using the 504 sample size for the first year. Once a State has a baseline error rate, it can use that rate to determine its next measurement sample size.

Comment: One commenter requested clarification and additional guidance concerning the development and submission of a sampling plan, monthly samples and sample lists. One other commenter stated that the supporting statement implied that CMS approval of the state's sampling plan means that the agency also approves a state's eligibility review methodology.

Response: CMS will be providing more specific instructions regarding the operation of PERM eligibility sampling and review process in the fall. The first year eligibility is measured, FY 2007, the State shall submit their sampling plan on November 15, 2006. Each State selected for measurement shall adhere to the nationally standardized review methodology that will be included in the instructions.

Comment: There is insufficient detail explaining the necessity for and detail required for the monthly sample list.

Response: CMS is requesting a list of sampled cases with the case/beneficiary identification and strata location as on the sample form. CMS will use the summary findings to compare to the monthly sample lists to determine that the State completed its reviews of the selected cases.

Comment: It may be more appropriate for a State to select an "enrollee-based" sample rather than a "case-based" sample.

Response: Case means individual beneficiary.

Comment: A few commenters asked CMS to please clarify the sampling parameters states are expected to use to select the monthly samples of the three unique strata of active cases/beneficiaries: confidence level, confidence interval, and estimated margin of error. Also, please specify the sampling parameters states should use to select the monthly sample of negative cases which are not stratified.

Response: The detailed methodology as to sampling parameters will be included in the instructions.

Comment: One commenter requests that CMS clarify whether States should assume that they should calculate sample size without reference to a particular estimate of error, e.g., the mid-point.

Response: For FY 2007, we have provided the sample size for active and negative cases. Therefore, States will not need to calculate the sample size.

Comment: For stratum three cases, States are instructed to review the eligibility as of the sample month if the last State action was taken more than 12 months prior to the sample month. The precision of the payment error rate could be affected if the review methodology varies to consider information available at the time of the eligibility determination for some cases and actual circumstances for others.

Response: PERM will allow States to use their own eligibility policies and standards as long as they comply with the state plan, federal law and regulation. Federal regulation for Medicaid and SCHIP provide that each program have a procedure in place to determine eligibility at least annually.
From a purely statistical viewpoint, we do recognize if those strata three cases that fall outside of the annual redetermination have different error rates than those that fall within the annual timeframe , provides an additional component of variance in the estimated error rate. For a given sample size, greater variation in the error rate will reduce precision. The additional variation in the error rate will depend on the proportion of cases in strata three that fall into that category, and the difference in the probability of error for the two types of strata three cases. However, we believe that, in those instances where there hasn’t been a State action within 12 months, the State should not be held harmless when it has not

complied with the requirements at 42 CFR 435.916(a) and 457.320(e) (2) to redetermine eligibility at least annually.

Comment: One commenter requested that CMS provide further information on the method that the federal contractor will use to determine how PERM claim and payment error rate review criteria can be met in those States that have stand-alone SCHIP programs rather than a Medicaid expansion program.

Response: The States will be conducting the eligibility reviews, collecting the payments associated with errors and calculating their own error rates. All cases funded under Title XIX will be measured under the Medicaid program and all cases funded under Title XXI will be measured under the SCHIP program. The fact that a SCHIP program includes Medicaid expansion cases is not relevant.

Comment: One commenter suggested that CMS consider other case types for exclusion from PERM reviews, i.e., cases in fair hearing status and cases where the sampled person is discovered to have SSI eligibility under a different program number or are under active fraud investigation by another program such as food stamps.

Response: CMS will consider this comment.

Comment: Will there be weighting to balance proportions to the three strata? It is possible that the same action will be sampled more than once during the fiscal year. Would a case drawn for review of an application in November be subsequently reviewed for the same action when sampled in March from the frame of active ongoing cases?

Response: The eligibility process does not provide for dropping cases from review if it is sampled more than once in the fiscal year.

Comment: One commenter asked that when a SCHIP beneficiary is going through the redetermination process, they are determined to be “provisionally eligible” pending Medicaid determination, and would they be considered in strata 2 upon the provisional redetermination or final redetermination?

Response: This a State-specific operational detail that we can address as we progress with the eligibility reviews this year.

As stated earlier, we cannot address all specific operational and technical aspects of the program in this information collection process; particularly if the issue does not pertain to cost and burden.
Comment: What case exclusions from the universe were allowed?

Response: We propose to exclude cases for which the Social Security Administration, under a section 1634 agreement with a State, determines Medicaid eligibility for Supplemental Security Income recipients, are excluded from the Medicaid universe. All foster care and adoption cases under Title IV-E of the Act are excluded from the Medicaid universe in all states. Active beneficiary fraud cases are excluded from the Medicaid and SCHIP universe.

Comment: CMS should provide clarification of what is considered a completed application for stratum 1 and what is a completed redetermination for stratum 2 for the sample month. Should applications that are opened as administrative applications such as reopenings following an appeal reversal, be excluded from the universe for stratum 1? Some states have reapplications in which a case is reopened following a termination action, such as a case that is incorrectly terminated. Would these completed reapplications be included in the universe for stratum 1 or stratum 2?

Response: The placement of a case in the active or negative universe and appropriate strata is determined by the last action the State takes on a case based on a completed application or redetermination. More clarifications will be provided in the instructions.

Reporting
Comment: Is it CMS' interpretation that States must report findings by the end of the month from which the sample was drawn?

Response: CMS proposes to collect detailed and summary findings on the eligibility and payment reviews as outlined in the cost and burden section of the supporting statement.

Comment: There is insufficient detail explaining the structure and function of the corrective action plan, i.e., will corrective action plans require CMS approval? Will CMS monitor the implementation and results of corrective action plans? Can a model corrective action plan be agreed upon by the States prior to data collection? Can CMS establish a steering committee to

ensure PERM contractors address data collection issues before beginning reviews?

Response: We are not able to respond to the operational aspects of the corrective action process because we have not finalized our corrective action plan at this time.

Comment: A commenter requested clarification as to the frequency of reporting the error rate.

Response: The error rate will be reported once at the end of the eligibility measurement.

Comment: CMS seems to be requesting that States send their monthly selection lists during the review cycle and error findings and a corrective action plan afterwards. Does this mean that monthly "progress reports" are not required during the review cycle?

Response: We expect monthly progress reports during the review cycle to ensure States are completing reviews timely and the cost and burden was revised accordingly.