New York State
Office of the Medicaid Inspector General
Riverview Center
150 Broadway
Albany, NY 12204

New York State Department of Health
Corning Tower
The Governor Nelson A. Rockefeller
Empire State Plaza
Albany, NY 12237

July 24, 2006

Rec'd
JUL 25 2006

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development-A
Attention: Melissa Musotto Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Musotto:

This is in response to a request for comments on CMS-372(s), CMS-2746, CMS-10190, CMS-10183, CMS-2744, CMS-10194, and CMS-10184. As interested parties are aware, New York was one of several states selected by the Department of Health and Human Services' Office of Inspector General (OIG) to determine the extent to which the State agency made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements. Based on this selection by OIG and our participation on the Payment Error Rate Measurement Eligibility Workgroup, we believe we are uniquely situated to provide comments on this rule.

New York State is pleased with the willingness of CMS to not only seek states' input to the process, but also their willingness to make reasonable adaptations and changes including allowing Medicaid Eligibility Quality Control (MEQC) reviews to be, with CMS approval, substituted for PERM eligibility reviews at the State's **option**.

The Medicaid program, and particularly one as diverse as New York's, is challenging for persons unfamiliar with its complexities and nuances to interpret. It was our observation that, for the most part, OIG audit staff was unfamiliar with all but the most rudimentary aspects of the policies and systems of the New York State Medicaid program. State staff spent months explaining Medicaid policy, procedures and systems to OIG auditors. Despite their extensive efforts, we were not able to determine from the information contained in the draft report how the auditors applied this information or how they arrived at their conclusions.

It appears that audit staff may have relied on interpretations of federal regulations that are not consistent with interpretations and instructions States have received from the Centers for Medicare and Medicaid Services (CMS). For example, auditors repeatedly cite the requirement to have "facts" in the file to support an eligibility determination, but seem to equate "facts" with independent documents that are not required by CMS. In fact, the CMS PERM Workgroup recommended that caseworker notes recorded during the review of eligibility be accepted as documentation/corroboration of information or "facts" as sought by the OIG auditors. We support this recommendation regarding the use of caseworker notes. Until the recent passage of the Deficit Reduction Act (DRA), which requires documentation of citizenship, the only specific documents required were those pertaining to immigration status, a point made by CMS numerous times as states attempted to improve access to health care.

We have attached a copy of the OIG draft report "Review of Medicaid Eligibility in New York State," as well as our response which we believe provides insight and supports the comments delineated below.

Background

In order to comply with the completion of Medicaid eligibility reviews in the same year the states are selected for Medicaid or SCHIP FFS and managed care reviews, states will have to hire double the number of staff to perform these functions simultaneously. These costs can be avoided by conducting the eligibility and claims reviews in different years; thus allowing one cadre of staff to be trained and hired for both purposes. By doing this, CMS and OIG staff will have the opportunity to more fully analyze the information states have provided, and states will be afforded more time to address CMS systems requests.

States are required to select monthly samples and conduct the eligibility reviews using a CMS standardized review methodology. We are very interested in the "standardized review methodology" and feel that states must be provided an opportunity to review this document before it is finalized. This is particularly important given our experience with the OIG auditors who seemed not to be persuaded by CMS guidance issued to states when reviewing the accuracy/documentation of the state's record/determination (see Attachment 1).

It is difficult to comment on the data collection requirement in the abstract. Without knowing the actual protocols that states must follow to provide data, it is impossible to accurately comment on the effect. When and in what form will CMS provide the actual rules that states must follow?

Similar to comments made by the American Public Human Services Association (APHSA), we understand that the Supporting Statement and previous regulatory documents provide that the Improper Payments Information Act of 2002 requires that CMS produce a national error rate. The statute in no way confers authority to the federal agencies to determine and utilize a state specific error rate for the purpose of imposing fiscal penalties on individual states. We agree that CMS

should clarify in future guidance that fiscal penalties will not be conferred upon the states.

We understand that the PERM program will result in "reviews." We request that CMS specify whether such reviews will include "findings." If so, how will CMS utilize these findings and what agencies, organizations, individuals or other entities will have access to such information?

Clarification regarding the formula states will be required to use to calculate the state-specific eligibility error rate based on the review results is requested. In addition, we request further clarification for the formula that will be used to calculate the state-specific payment error rate that is uniquely attributable to eligibility errors.

Justification

It is not clear that CMS has taken all potential costs into account in the Burden of Estimate (total hours and wages), and in fact may not be able to at least in the first year. The eligibility reviews entail a large workload and cost and many states are facing shortfalls in their SCHIP allotments and will not have the resources to conduct these reviews. Specifically, we note the following:

- It is unlikely that a state can initiate and support the eligibility effort for $532,340.20.
- In order to support the PERM eligibility initiative, it appears that states will need to hire and train additional staff.
- It is arbitrary and unreasonable to calculate total cost (per state, per program) using a GS-12 salary as the base and the CMS fringe and overhead rates. The three figures, salary, fringe and overhead, will vary widely from state to state. It would be more appropriate to develop a range for the burden estimate. One of the larger states reported that just to hire and train seven reviewers to complete eligibility reviews would cost over $640,000.

We agree with the APHSA that CMS could avoid considerable criticism by ensuring that states have the resources to adequately support the PERM project by providing 100% federal reimbursement.

If a state opts to perform, and CMS approves, traditional MEQC to meet the PERM eligibility requirement, will MEQC penalties apply to PERM? States choosing to substitute the MEQC review for the PERM eligibility review should have the state's most recently reported MEQC error rate as meeting MEQC requirements while the state's MEQC staff performs PERM eligibility review duties. Such consideration will enable states to take advantage of the efficiencies of substituting MEQC review for the PERM eligibility review.

Sample Size Development

In order to assure that sufficient staff are hired and trained for PERM eligibility purposes, New York is seeking confirmation of the sample size, as a 1% variation in New York with over 4 million Medicaid recipients, could translate into a significant increase in the sample requiring review. Does CMS anticipate that all states will review 701 cases for eligibility, regardless of the size of the state caseload? Will there be any sample size differential based on state caseload?

Case Reviews

We echo APHSA's previous comment that deriving state-specific error rates goes beyond the requirements of the Improper Payments Information Act of 2002 (IPIA) and welcome an opportunity for states' statisticians to review and comment on the relevance and reliability of the methodology for determining the rates.

Federal regulations at 42 CFR 431.804 provide an Administrative Period in the MEQC program for State agencies to reflect changes in case circumstances, i.e. a change in a common program area, during which no case error based on the circumstance change would be cited. This period consists of the review month and the month prior to the review month. We are concerned that an Administrative Period is not allowed in PERM eligibility reviews and would like to understand the rationale. The period of time (Administrative Period) during which a case may have federally required aid-continuing pending a fair hearing on a negative decision, or the period between the decision and the tolling of a federally required timely eligibility notice to the client would not count against the state if in fact the negative decision was found to be correct. Similarly, we believe that an Administrative Period should be allowed when pursuant to federal guidance an otherwise ineligible case must remain open pending the provision of necessary documentation/information by the recipient to support their continued eligibility.

Clarification as to the definition of the last action taken by the State as referred to on page 7 is required. The CMS PERM workgroup recommended that the last action taken be defined as an action which included an assessment of eligibility. We support the workgroup's recommendation on this issue.

We agree with APHSA's recommendation that payment error rates include a payment error tolerance threshold. During the PERM pilot in at least one state, the SSA BENDEX Report was off by $1 to $2 after each annual COLA. This resulted in spend-down errors of $6-$12 each six-month spend-down period. States should be able to rely on the BENDEX as well as all federal files for verification of SSA income and other factors of eligibility. PERM eligibility reviews should allow for at least a $12 payment error tolerance threshold.

Sampling negative cases will be problematic for New York's SCHIP program. Since we have a common application for Medicaid and SCHIP and a buy-in to SCHIP, very few children are ineligible for one of the programs.

Applications screened eligible for Medicaid are routed directly to the Medicaid program. Those found ineligible for subsidized SCHIP coverage are provided an opportunity to purchase the coverage at full premium. Essentially, no one is denied, but some may not accept coverage at full premium. One way we could accommodate the negative case reviews is to review the eligibility of those enrolled at full premium. They are not eligible for SCHIP. Any more than that will require programmatic changes that will be burdensome to the state and its managed care partners.

For the active and negative cases, it would be helpful for the states to have eligibility review flowcharts. These flowcharts would support consistency among the states.

With regard to the estimated need for resources, an additional 2,135 hours were added to the 7,845 case review hours CMS estimated for supporting functions like training, supervision, quality assurance and creation of review tools, etc.

Adequate training of eligibility case reviewers alone would be in excess of 1,000 hours, thus leaving only about 1,000 hours of supervision, coordination, re-reviews, creation of review tools, tracking programs, quality assurance, etc. 1,000 hours is not enough to accomplish these supporting functions.

Collections of Information Employing Statistical Methods

In this section, paragraph 3 advises "states are to report findings monthly and on an annual basis for the year selected...." If CMS interprets that to mean states must report case review findings in January by the end of that month, such timeframe is unreasonable. If that is not the interpretation, clarification is needed relative to the timeframe for submission of case findings.

Again, we thank you for the opportunity to provide comments and are available to meet or discuss these issues further. Please feel free to contact Linda LeClair at 518-474-8887 if you have any questions.

Sincerely,

Kimberly A. O'Connor
Medicaid Inspector General

Brian J. Wing
Deputy Commissioner
Office of Medicaid Management

Attachments
cc: Martha Roherty, APHSA

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region II
Jacob K. Javits Federal Building
New York, New York 10278
(212) 264-4620

April 28, 2006

Report Number: A-02-05-01028

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Department of Health
Empire State Plaza
Corning Tower, 14th Floor, Room 1408
Albany, New York 12237

JUL 25 2006

Dear Dr. Novello:

Enclosed are two copies of the Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled "Review of Medicaid Eligibility in New York State."

This draft is not to be considered final as it is subject to further review and revision. Please safeguard it against unauthorized use. To properly consider and present your views concerning the validity of the facts and reasonableness of the recommendations, we request that you provide us with written comments within 30 days of the date of this letter. Please include in your written comments the status of any action taken or contemplated on our recommendations.

Your formal response will be summarized in the body of our final report and included in its entirety as an appendix. In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are made available to the public to the extent the information is not subject to exemptions in the Act (See 45 CFR Part 5). As such, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please contact Brenda Ryan at (212) 264-4677 or through email at Brenda.Ryan@oig.hhs.gov. Please refer to report number A-02-05-01028 in all correspondence.

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosures

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID ELIGIBILITY IN NEW YORK STATE

NOTICE – THIS DRAFT RESTRICTED TO OFFICIAL USE

This document is a draft report of the Office of Inspector General and is subject to revision; therefore, recipients of this draft should not disclose its contents for purposes other than for official review and comment under any circumstances. This draft and all copies thereof remain the property of, and must be returned on demand to, the Office of Inspector General.

Daniel R. Levinson
Inspector General

April 2006
A-02-05-01028

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program pays for medical assistance for certain individuals and families with low income and resources. The Federal and State Governments jointly fund and administer the program. The Centers for Medicare & Medicaid Services (CMS) administers the program at the Federal level.

Federal and State laws, regulations, and other requirements establish Medicaid eligibility. Generally, an individual must, among other things, not exceed income and resource thresholds established by the State, meet citizenship requirements, submit a written application for Medicaid benefits, furnish his or her Social Security number, meet beneficiary liability requirements, and be eligible for the specific services received. The State must include in each applicant's case file facts to support the State's eligibility determination. In addition, the State must have a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility decisions.

In New York State, the Department of Health (the State agency) administers the Medicaid program. The State agency's district offices determine the eligibility of applicants for Medicaid benefits. From January 1 through June 30, 2005, the State agency made more than 52.7 million payments totaling $10.7 billion ($5.4 billion Federal share) on behalf of Medicaid beneficiaries.[1]

CMS and the Office of Management and Budget requested this audit.

OBJECTIVE

Our objective was to determine the extent to which the State agency made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

SUMMARY OF FINDINGS

For the period January 1 through June 30, 2005, the State agency (1) made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations.

Of the 200 payments in our statistical sample, 16 payments totaling $874 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. Specifically, the State agency made:

- 12 payments on behalf of beneficiaries whose household incomes exceeded the Medicaid income threshold on the dates of service, who did not meet the waiting period for certain

[1]This number excludes payments made for Medicaid beneficiaries who are automatically eligible for Medicaid because of their eligibility category and the State Children's Health Insurance Program Medicaid expansion.

DRAFT

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by monitoring eligibility decisions. In addition, the regulations contain procedures for disallowing Federal payments for erroneous Medicaid payments that result from eligibility and recipient liability errors above a certain level, as detected through the MEQC program. Federal regulations (42 CFR § 431.804) define an eligibility error as an instance in which Medicaid coverage was authorized or payment was made for a beneficiary who (1) was ineligible for Medicaid when authorized or when he/she received services, (2) was eligible for Medicaid but was ineligible for certain services received, or (3) had not met beneficiary liability requirements (e.g., beneficiary had not incurred medical expenses in an amount necessary to lower his countable income to the threshold limit).

A Medicaid beneficiary must be a resident of the State from which the beneficiary receives Medicaid benefits, and a citizen or national of the United States or a qualified alien.[1] Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, as codified, in part, at 8 U.S.C. 1601-1646, provides that legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Medicaid for the first 5 years after entry.

Medicaid income and resource thresholds are established by the State, subject to certain restrictions, and must be included in the State plan.[2] The income and resource thresholds vary based upon eligibility category and the number of family members in the household, and are subject to yearly adjustments.[3] Unlike most other eligibility categories, regulations (42 CFR § 435.831(d)) require the State to deduct certain incurred medical expenses from income when determining financial eligibility for beneficiaries in the "medically needy" category. This process is often referred to as "spenddown." In addition to the income and resource thresholds, some eligibility categories have other requirements. For example, for beneficiaries not receiving Supplemental Security Income (SSI) who apply for Medicaid under the eligibility category for blind or disabled persons, regulations (42 CFR §§ 435.531 and 435.541) require that the determination of blindness or disability be based on a physician's report of examination.

Regulations (42 CFR § 435.910) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her Social Security number to the State. The State must contact the Social Security Administration to verify that the number furnished was the correct number and the only number issued to the individual. If the applicant cannot recall his or her Social Security number or was not issued a Social Security number, the State must assist the individual in obtaining a number or identifying his or her existing number. The State cannot

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[1]Undocumented aliens are only eligible for Medicaid pregnancy and emergency services.

[2]Children and pregnant women may qualify at higher income levels than other types of applicants.

[3]One eligibility criteria for the optional category for women in need of treatment for breast or cervical cancer is that the woman must have been screened for breast or cervical cancer through the Centers for Disease Control and Prevention breast and cervical cancer early detection program, which is aimed at low-income, uninsured, and underserved women. However, pursuant to sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act, once screened through the early detection program, a woman is eligible for Medicaid under this optional category regardless of her income or resources, if the woman: (i) needs treatment for breast or cervical cancer; (ii) is not otherwise eligible for Medicaid; (iii) is under age 65; and (iv) is uninsured.

Scope

Our audit period covered January 1 through June 30, 2005. We did not review the overall internal control structure of the State Medicaid program. Rather, we reviewed the State agency's procedures relevant to the objectives of the audit.

We performed fieldwork from October 2005 to January 2006 at the State agency's offices in Albany and New York, NY, the New York City Human Resource Administration (a State agency district office) in New York, NY, and the State MMIS fiscal agent in Rensselaer, NY.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and other requirements related to Medicaid eligibility;

- held discussions with CMS headquarters and regional office officials and with State officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;

- ran computer programming applications at the MMIS fiscal agent that identified 100,365,212 Medicaid fee-for-service and managed care payments totaling approximately $18.1 billion (approximately $9.1 billion Federal share) for services rendered in New York for the period January 1 through June 30, 2005;

- eliminated from the total number of Medicaid payments (1) 46,093,239 Medicaid payments totaling approximately $7.1 billion (approximately $3.6 billion Federal share) made on behalf of SSI recipients, and (2) 625,352 Medicaid payments totaling approximately $130.4 million (approximately $65.3 million Federal share) made on behalf of recipients of adoption assistance and foster care under Title IV-E of the Act because beneficiaries in these categories are automatically eligible for Medicaid services;

- eliminated from the total number of Medicaid payments 923,026 State Children's Health Insurance Program Medicaid expansion payments totaling approximately $87.7 million (approximately $56.3 million Federal share) because we included these payments in another, ongoing review (report number A-02-06-01003);

- identified a universe of 52,723,595 payments totaling approximately $10.7 billion (approximately $5.4 billion Federal share) for services rendered to Medicaid beneficiaries in New York during the 6-month period ended June 30, 2005; and

- selected a simple random sample of 200 payments from the universe of 52,723,595 payments, as detailed in Appendix A.

payments for services rendered to Medicaid beneficiaries, (1) the dollar impact of the improper Federal funding for ineligible beneficiaries and (2) the dollar impact of the payments for which documentation did not support eligibility determinations.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATION

The State agency (1) made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations. Of the 200 payments in our statistical sample, 16 payments totaling $874 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. In addition, for 58 payments totaling $10,699 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required.

As a result, for our 6-month audit period, we estimate that the State agency made 4,217,888 payments totaling $230,375,748 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 15,289,843 payments totaling $2,820,569,979 (Federal share).

ELIGIBILITY ERRORS

The table below summarizes the 16 eligibility errors noted in the sampled payments.

Eligibility Errors and Associated Unallowable Payments

Eligibility Error	Number of Unallowable Payments	Unallowable Federal Payments
Beneficiaries were ineligible:		
Did not meet income requirements on dates of service	6	$378
Did not meet the waiting period for certain qualified aliens	3	154
Did not reapply for continued coverage	2	63
Did not furnish a Social Security number	1	87
Subtotal	**12**	**$682**
Beneficiaries had not met liability requirements	2	$131
Beneficiaries were ineligible for certain services	2	61
Total	**16**	**$874**

the monthly income threshold in the State is $1,000 and the beneficiary is earning $1,200, the beneficiary must have medical expenses equal to or greater than $200 to qualify for Medicaid. A Medicaid payment is unallowable when these beneficiary liability requirements have not been met, and such payments should be identified as an eligibility error under the State's MEQC program.

For two sampled payments totaling $131 (Federal share), the State agency paid for services rendered to beneficiaries who had countable income above the income threshold on the dates of service and who had not met the beneficiary liability requirements.

Beneficiaries Were Ineligible for Certain Services

Federal regulations (42 CFR § 431.804) define one type of eligibility error as "Medicaid coverage has been authorized or payment has been made for a recipient . . . [who] was eligible for Medicaid but was ineligible for certain services he received. . . ."

Section 369-ee of the New York State Social Services Law provides eligibility and coverage criteria for the FHPlus program. Pursuant to section 369-ee, FHPlus provides comprehensive health insurance to low-income adults aged 19 through 64 who are not pregnant, who have income or resources above the thresholds for the other Medicaid categories, and who do not have other health insurance coverage. Section 369-ee provides that the FHPlus benefit package includes primary, preventive, specialty, and inpatient care provided through managed care plans. Thus, beneficiaries who are eligible only for FHPlus are not eligible for services provided on a fee-for-service basis.

For two sampled payments totaling $61 (Federal share), the State agency provided Medicaid coverage to beneficiaries for specific services not covered under the beneficiaries' eligibility categories. The two payments were fee-for-service payments for beneficiaries with incomes at the dates of service within the requirements for FHPlus but above the thresholds for the other Medicaid categories. Thus, although the two beneficiaries were eligible only for FHPlus, the State agency district office classified the beneficiaries in other coverage categories. Under FHPlus, all health care services are provided through the managed care plan and are not separately billable.

INSUFFICIENT DOCUMENTATION TO SUPPORT ELIGIBILITY DETERMINATIONS

Federal regulations (42 CFR § 435.907(a)) require a written application from each applicant. The regulations (42 CFR §§ 435.911(a) and 435.916(a)) also require the State to (1) determine Medicaid eligibility within 90 days for applicants who apply based on disability and within 45 days for all other applicants and (2) redetermine eligibility at least every 12 months. In addition, the State must include in each applicant's case file facts to support the State's decision on the application (42 CFR § 435.913(a)).

For 58 sampled payments totaling $10,699 (Federal share), the case files did not contain adequate documentation to support eligibility determinations. Each case file was missing at least

APPENDIXES

We sequentially numbered the claims in our sampling frame and selected the random numbers that correlated to the sequential numbers assigned to the claims in the sampling frame. We then created a list of 200 sampled items.

CHARACTERISTICS TO BE MEASURED

We based our determination as to whether each sampled payment was unallowable on Federal and State laws, regulations, and other requirements. Specifically, if at least one of the following characteristics was met, we considered the payment under review unallowable:

- The beneficiary did not meet one or more eligibility requirements.
- The beneficiary had not met liability requirements when authorized for participation in the program.
- The beneficiary was eligible for Medicaid but ineligible for the service rendered.

In addition, we also determined whether the case files contained sufficient documentation to support the eligibility determination as required by Federal regulations.

ESTIMATION METHODOLOGY

We used both the OAS attributes and variables appraisal programs in RAT-STATS to appraise the sample results.

We used the attributes appraisal program to estimate the total number of payments made for Medicaid beneficiaries who did not meet eligibility requirements and the total number of payments for which documentation did not support eligibility determinations. We also used the variable appraisal program to estimate the total amount of Federal payments made for ineligible Medicaid beneficiaries and the total amount of Federal payments for which documentation did not support eligibility determinations.

INSUFFICIENT DOCUMENTATION

The results of our review of the 200 Federal Medicaid payments were as follows:

Sample Results

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Payments With Insufficient Documentation	Value of Payments With Insufficient Documentation (Federal Share)
52,723,595	$5,377,058,250	200	$26,706	58	$10,699

Projection of Sample Results
Precision at the 90-Percent Confidence Level

	Attributes Appraisal	Variables Appraisal
Midpoint	15,289,843	$2,820,569,979
Lower Limit	12,512,778	$1,545,965,763
Upper Limit	18,316,064	$4,095,174,195

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 29, 2006

James P. Edert
Regional Inspector General for
Audit Services
DHHS OIG Office of Audit Services
26 Federal Plaza
Room 3900A
New York, New York 10278

JUL 25 2006

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the DHHS – OIG's Draft Audit Report (A-02-05-01028) on "Review of Medicaid Eligibility in New York State."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Mr. Charbonneau
Mr. Griffin
Mr. Howe
Ms. Kelly
Ms. Napoli
Ms. O'Connor
Mr. Reed
Ms. Rice
Mr. Seward
Mr. Wing 14

Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-05-01028 on
"Review of Medicaid Eligibility in New York State"

The following are the Department of Health's (DOH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) draft audit report (A-02-05-01028) on "Review of Medicaid Eligibility in New York State."

Recommendation #1:

The Department should (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require district office employees to verify eligibility information and maintain appropriate documentation in all case files.

Response #1:

Staff has a number of comments and observations regarding both the draft report and the audit process on which the findings and recommendations are based.

Through numerous eligibility categories, the New York State Medicaid program provides comprehensive, high quality health care coverage and services to more than four million low income residents of New York State who would otherwise lack access to medical care.

The New York State Medicaid program is centrally supervised by the New York State Department of Health, and administered by the State's 58 local departments of social services (LDSS). Trained staff take applications and determine Medicaid eligibility by evaluating information from a combination of sources: face-to face interviews with applicants, documents required from and supplied by applicants, and behind-the-scenes interfaces and verification with a number of data sources to resolve or clarify any discrepancies found.

Data sources include the agencies' own files, such as the Welfare Management System (WMS). As directed by the Centers for Medicare and Medicaid Services (CMS) and OIG in State Medicaid Director Letter #01-015, states are to streamline and simplify the Medicaid application process, as well as to rely on information gathered from other programs. Specifically, Medicaid agencies are not to redocument information already in agency files that is not subject to change. This would include applicant information such as proof of citizenship, date of birth and copies of social security cards. Verification of these types of information is imbedded in other routinely accessible reports or through one or more of the State data systems.

The Medicaid program, and particularly one as diverse as New York's, is challenging for persons unfamiliar with its complexities and nuances to interpret. It was our observation that, for the most part, OIG audit staff were unfamiliar with all but the most general aspects of the systems and components of the New York State Medicaid program. Department staff spent months explaining Medicaid policy, procedures and systems to OIG auditors. Despite their extensive efforts, we are not able to determine from the information contained in the draft report how the auditors applied what they were told or how they arrived at their conclusions. The Department will need actual work papers to assess their findings.

From the report, it appears that audit staff may have relied on interpretations of federal regulations that are not consistent with instructions the State has received from CMS. For example, auditors repeatedly cite the requirement to have "facts" in the file to support an eligibility determination, but seem to equate "facts" with independent documents that are not required by CMS. Until the passage of the Deficit Reduction Act, which requires documentation of citizenship, the only specific documents required were those pertaining to immigration status, a point made by CMS numerous times as states attempted to improve access to health care.

Other examples of the differences between Medicaid rules and guidance, and the audit approach, include the following:

- Refusal to accept the WMS systems logic and to recognize the validity of client-specific vital records data contained within WMS. The lack of understanding in this area was evidenced by the insistence on "seeing" client documentation known to WMS but related to earlier cases. Many clients had been associated with other cases as children, and moved to new cases as they aged and/or their family units changed. However, the "paper" proving basic, unchanging client demographics such as date of birth, although verifiable through WMS, remained with the original case record. For an individual known to the system for 10 to 15 years or longer, as are many of our Office of Mental Retardation and Developmental Disabilities (OMRDD) recipients, much of the individual's original case files would be difficult to locate or retrieve from archives.

- Questions about whether New York State was providing Medicaid benefits to individuals who did not reside in the State. Many elderly recipients have a representative payee, frequently a son or daughter, whose residence would be listed in the case record for purposes of notification. That residence may be outside of New York State. In other instances, a recipient may have been placed by New York State in an out-of-state facility for medical reasons.

- Findings that recipients did not meet their Medicaid liability. Satisfaction of recipient liability can be achieved in many ways: use of unpaid bills, some of which can be carried forward for several months; use of bills paid by other programs such as New York's Elderly Pharmaceutical Insurance Coverage (EPIC) program;

payments entered into district-administered recipient pay-in accounts – which are all part of WMS – or principal provider payment deductions incorporated into eMedNY (MMIS). OIG audit staff was unfamiliar with these generally accepted methods and did not accept the logic of WMS's principal provider subsystem and its ability to systematically reduce provider payments by the appropriate recipient liability amount.

- References to use of Medicaid Eligibility Quality Control (MEQC) procedures that fail to recognize the State's federal waiver for targeted MEQC reviews.

Finally, as program experts and not statisticians, the Department does not have any way to evaluate the auditors' methods of extrapolating from findings, accurate or not, to the full spectrum of Medicaid payments. Therefore, we are requesting a layperson's explanation of the "attributes appraisal" and "variables appraisal" programs – in particular, the underlying assumptions, the way these programs use data, and the contexts in which they are normally used.

The report does contain findings that can be acted upon, and we are taking immediate steps to do so. For example, ensuring that applications contain applicant signatures is certainly something that will be reinforced for our LDSS. The Department's Office of Medicaid Management (OMM) has also increased its monitoring of eligibility processes and outcomes in local districts, an activity made possible by the addition of staff to OMM's Local District Support Unit over the past several months. Districts are being reminded to impress upon applicants their responsibilities and their rights when they apply. Despite our best efforts, however, some applicants may conceal or fail to report information that would be vital to maintaining their eligibility.

This audit, which we understand was intended to help inform Payment Error Rate Measurement (PERM) regulations regarding Medicaid eligibility, appears to establish a standard for supporting eligibility determinations that is far more stringent than anything upon which the federal Medicaid program has operated to date. We cannot assess whether this derives from a perspective unfamiliar with program operations, or from a change in federal policy that has not yet been articulated to states through regular communication channels.

We look forward to receiving the requested materials, and would welcome a dialogue on this very important review as you move forward in establishing audit protocols that will be used in PERM.

STATE OF NEW YORK DEPARTMENT OF HEALTH
OFFICE OF MEDICAID MANAGEMENT
INTEROFFICE MEMORANDUM

TO: Thomas Howe, Director
Audit Unit

FROM: Brian Wing, Deputy Commissioner
Office of Medicaid Management

DATE: May 18, 2006

SUBJECT: DHHS-OIG Draft Audit (A-02-05-01028) – "Review of Medicaid Eligibility in New York State"

Attached is a letter in response to the above subject OIG Draft Audit for your review and processing. It has also been electronically mailed to you should any revisions need to be made.

Attachment

Wing

STATE OF NEW YORK - DEPARTMENT OF HEALTH

INTEROFFICE MEMORANDUM

TO: Brian J. Wing, Deputy Commissioner
Office of Medicaid Management

FROM: Thomas Howe, Director
Audit Unit

SUBJECT: DHHS-OIG Draft Audit (A-02-05-01028) – "Review of Medicaid Eligibility in New York State"

DATE: May 2, 2006

Enclosed for your review and comment is a copy of the Office of Inspector General's Draft Audit Report No. A-02-05-01028 entitled "Review of Medicaid Eligibility in New York State." A formal process must be followed both prior to, and subsequent to, the release of this audit in its final form.

1. Specifically, the Department is required, at a minimum, to respond to all recommendations. You may either agree or disagree with a recommendation, but should provide reasons if you disagree or provide an alternative solution that achieves similar ends. In addition, an abbreviated description of the steps you intend to take to correct the problem, and a target date for completion, would be helpful. Your comments should address the issues raised in a constructive manner and provide clear, substantive responses to recommendations.

2. If the findings and examples cited by DHHS are incorrect or erroneously interpreted, you can rebut each instance, but be prepared to provide specific supporting documentation.

To meet DHHS' deadline, I would appreciate receiving your comments not later than May 22, 2006. Thank you for your assistance.

Enclosure

cc: Mr. Charbonneau
Ms. Napoli
Ms. O'Connor
Mr. Reed
Mr. Seward
Pend 5/22/2006

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services
Region II
Jacob K. Javits Federal Building
New York, New York 10278
(212) 264-4620

April 28, 2006

Report Number: A-02-05-01028

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Department of Health
Empire State Plaza
Corning Tower, 14th Floor, Room 1408
Albany, New York 12237

Dear Dr. Novello:

Enclosed are two copies of the Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled "Review of Medicaid Eligibility in New York State."

This draft is not to be considered final as it is subject to further review and revision. Please safeguard it against unauthorized use. To properly consider and present your views concerning the validity of the facts and reasonableness of the recommendations, we request that you provide us with written comments within 30 days of the date of this letter. Please include in your written comments the status of any action taken or contemplated on our recommendations.

Your formal response will be summarized in the body of our final report and included in its entirety as an appendix. In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are made available to the public to the extent the information is not subject to exemptions in the Act (See 45 CFR Part 5). As such, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please contact Brenda Ryan at (212) 264-4677 or through email at Brenda.Ryan@oig.hhs.gov. Please refer to report number A-02-05-01028 in all correspondence.

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosures

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID ELIGIBILITY IN NEW YORK STATE

NOTICE – THIS DRAFT RESTRICTED TO OFFICIAL USE

This document is a draft report of the Office of Inspector General and is subject to revision; therefore, recipients of this draft should not disclose its contents for purposes other than for official review and comment under any circumstances. This draft and all copies thereof remain the property of, and must be returned on demand to, the Office of Inspector General.

Daniel R. Levinson
Inspector General

April 2006
A-02-05-01028

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program pays for medical assistance for certain individuals and families with low income and resources. The Federal and State Governments jointly fund and administer the program. The Centers for Medicare & Medicaid Services (CMS) administers the program at the Federal level.

Federal and State laws, regulations, and other requirements establish Medicaid eligibility. Generally, an individual must, among other things, not exceed income and resource thresholds established by the State, meet citizenship requirements, submit a written application for Medicaid benefits, furnish his or her Social Security number, meet beneficiary liability requirements, and be eligible for the specific services received. The State must include in each applicant's case file facts to support the State's eligibility determination. In addition, the State must have a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility decisions.

In New York State, the Department of Health (the State agency) administers the Medicaid program. The State agency's district offices determine the eligibility of applicants for Medicaid benefits. From January 1 through June 30, 2005, the State agency made more than 52.7 million payments totaling $10.7 billion ($5.4 billion Federal share) on behalf of Medicaid beneficiaries.[1]

CMS and the Office of Management and Budget requested this audit.

OBJECTIVE

Our objective was to determine the extent to which the State agency made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

SUMMARY OF FINDINGS

For the period January 1 through June 30, 2005, the State agency (1) made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations.

Of the 200 payments in our statistical sample, 16 payments totaling $874 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. Specifically, the State agency made:

- 12 payments on behalf of beneficiaries whose household incomes exceeded the Medicaid income threshold on the dates of service, who did not meet the waiting period for certain

[1]This number excludes payments made for Medicaid beneficiaries who are automatically eligible for Medicaid because of their eligibility category and the State Children's Health Insurance Program Medicaid expansion.

qualified aliens, who had not reapplied for continued coverage, or who did not furnish their Social Security number;

- 2 payments on behalf of beneficiaries who had no: met liability requirements; and
- 2 payments on behalf of beneficiaries who were eligible for Medicaid but not eligible for the specific service received.

In addition, for 58 sampled payments totaling $10,699 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required. Each case file was missing at least one of the following: an application covering the date of service, a signature on the application, and facts supporting income level, fulfillment of beneficiary liability requirements, residence, date of birth, and citizenship status.

As a result, for our 6-month audit period, we estimate that the State agency made 4,217,888 payments totaling $230,375,748 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 15,289,843 payments totaling $2,820,569,979 (Federal share).

We are not recommending recovery primarily because, under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's MEQC program.

RECOMMENDATION

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, the State agency should (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require district office employees to verify eligibility information and maintain appropriate documentation in all case files.

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INTRODUCTION

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) and the Office of Management and Budget requested this audit.

The Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program pays for medical assistance for certain individuals and families with low income and resources. The Federal and State Governments jointly fund and administer the program. CMS administers the program at the Federal level.

Within broad national guidelines established by Federal statutes, regulations, and other requirements, each State (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the payment rates for services; and (4) administers its own program. To participate in the Medicaid program, a State must receive CMS's approval of a State plan. The State plan is a comprehensive document that defines how each State will operate its Medicaid program, including program administration, eligibility criteria, service coverage, and provider reimbursement.

New York's Medicaid Program

In New York State, the Department of Health (the State agency) is responsible for operating the Medicaid program. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

The State agency requires that individuals submit written applications for Medicaid benefits. The State agency district offices review the applications and determine whether the individuals meet Medicaid eligibility requirements. For each applicant determined eligible, the district office sends a letter informing the individual of his or her responsibility to notify the district office of any changes that might affect eligibility status. Each year thereafter, the district office must verify any updated information and redetermine the individual's eligibility.

Federal Requirements Related to Medicaid Eligibility

Federal laws, regulations, and other requirements establish Medicaid eligibility requirements that a State plan must contain, the mandatory and optional groups of individuals to whom Medicaid is available under a State plan, and the eligibility procedures that the State agency must use in determining and redetermining eligibility.

Under Title XIX of the Act, Medicaid payments are allowable only for eligible beneficiaries. Generally, Federal regulations (42 CFR § 431.800 - 431.865) require the State to have a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures

by monitoring eligibility decisions. In addition, the regulations contain procedures for disallowing Federal payments for erroneous Medicaid payments that result from eligibility and recipient liability errors above a certain level, as detected through the MEQC program. Federal regulations (42 CFR § 431.804) define an eligibility error as an instance in which Medicaid coverage was authorized or payment was made for a beneficiary who (1) was ineligible for Medicaid when authorized or when he/she received services, (2) was eligible for Medicaid but was ineligible for certain services received, or (3) had not met beneficiary liability requirements (e.g., beneficiary had not incurred medical expenses in an amount necessary to lower his countable income to the threshold limit).

A Medicaid beneficiary must be a resident of the State from which the beneficiary receives Medicaid benefits, and a citizen or national of the United States or a qualified alien.[1] Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, as codified, in part at 8 U.S.C. 1601-1646, provides that legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Medicaid for the first 5 years after entry.

Medicaid income and resource thresholds are established by the State, subject to certain restrictions, and must be included in the State plan.[2] The income and resource thresholds vary based upon eligibility category and the number of family members in the household, and are subject to yearly adjustments.[3] Unlike most other eligibility categories, regulations (42 CFR § 435.831(d)) require the State to deduct certain incurred medical expenses from income when determining financial eligibility for beneficiaries in the "medically needy" category. This process is often referred to as "spenddown." In addition to the income and resource thresholds, some eligibility categories have other requirements. For example, for beneficiaries not receiving Supplemental Security Income (SSI) who apply for Medicaid under the eligibility category for blind or disabled persons, regulations (42 CFR §§ 435.531 and 435.541) require that the determination of blindness or disability be based on a physician's report of examination.

Regulations (42 CFR § 435.910) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her Social Security number to the State. The State must contact the Social Security Administration to verify that the number furnished was the correct number and the only number issued to the individual. If the applicant cannot recall his or her Social Security number or was not issued a Social Security number, the State must assist the individual in obtaining a number or identifying his or her existing number. The State cannot

[1]Undocumented aliens are only eligible for Medicaid pregnancy and emergency services.

[2]Children and pregnant women may qualify at higher income levels than other types of applicants.

[3]One eligibility criteria for the optional category for women in need of treatment for breast or cervical cancer is that the woman must have been screened for breast or cervical cancer through the Centers for Disease Control and Prevention breast and cervical cancer early detection program, which is aimed at low-income, uninsured, and underserved women. However, pursuant to sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act, once screened through the early detection program, a woman is eligible for Medicaid under this optional category regardless of her income or resources, if the woman: (i) needs treatment for breast or cervical cancer; (ii) is not otherwise eligible for Medicaid; (iii) is under age 65; and (iv) is uninsured.

deny or delay Medicaid services to an otherwise eligible individual pending issuance or verification of his or her Social Security number by the Social Security Administration. If an individual refuses to obtain a Social Security number for "well established religious objections," as defined in 42 CFR § 435.910(h)(2), the State can obtain a Social Security number on the individual's behalf or use another unique identifier. In redetermining eligibility, as required by 42 CFR § 435.916(a), regulations (42 CFR § 435.920(a)) provide that the State must determine whether the case records contain the recipient's Social Security number. Generally, pursuant to 42 CFR § 435.920(b), if the records do not contain the required Social Security number, the State must require the Medicaid recipient to furnish it.

Pursuant to 42 CFR § 435.916(b), the State must have procedures designed to ensure that beneficiaries promptly and accurately report any changes in circumstances that may affect eligibility. The State must promptly redetermine eligibility when beneficiaries report such changes or when the State anticipates a change in circumstances. Also, pursuant to 42 CFR § 435.916(a), the State must redetermine Medicaid eligibility at least every 12 months. Pursuant to 42 CFR § 435.940, the State must query appropriate Federal and State agencies to verify applicants' information when determining and redetermining eligibility.

State Requirements Related to Medicaid Eligibility

The State agency assigns individuals who are eligible for Medicaid to one of five coverage categories: (1) low-income families with children; (2) poverty-level children and pregnant women; (3) the aged, blind, and disabled; (4) the medically needy; or (5) State-specific eligibility groups, including individuals eligible under the Family Health Plus (FHPlus) program.

FHPlus provides comprehensive health insurance to low-income adults aged 19 through 64 who are not pregnant, who have income or resources above the thresholds for the other Medicaid categories, and who do not have other health insurance coverage.

The State plan incorporates the Federal requirements pertaining to residency, citizenship, blindness and/or disability, Social Security number, and beneficiary liability. The State plan also establishes income and resource levels. Section 366-a(4) of the New York State Social Services Law requires beneficiaries to inform the State agency district office of any changes in financial situation or any other changes affecting eligibility.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine the extent to which the State agency made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

Scope

Our audit period covered January 1 through June 30, 2005. We did not review the overall internal control structure of the State Medicaid program. Rather, we reviewed the State agency's procedures relevant to the objectives of the audit.

We performed fieldwork from October 2005 to January 2006 at the State agency's offices in Albany and New York, NY, the New York City Human Resource Administration (a State agency district office) in New York, NY, and the State MMIS fiscal agent in Rensselaer, NY.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and other requirements related to Medicaid eligibility;

- held discussions with CMS headquarters and regional office officials and with State officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;

- ran computer programming applications at the MMIS fiscal agent that identified 100,365,212 Medicaid fee-for-service and managed care payments totaling approximately $18.1 billion (approximately $9.1 billion Federal share) for services rendered in New York for the period January 1 through June 30, 2005;

- eliminated from the total number of Medicaid payments (1) 46,093,239 Medicaid payments totaling approximately $7.1 billion (approximately $3.6 billion Federal share) made on behalf of SSI recipients, and (2) 625,352 Medicaid payments totaling approximately $130.4 million (approximately $65.3 million Federal share) made on behalf of recipients of adoption assistance and foster care under Title IV-E of the Act because beneficiaries in these categories are automatically eligible for Medicaid services;

- eliminated from the total number of Medicaid payments 923,026 State Children's Health Insurance Program Medicaid expansion payments totaling approximately $87.7 million (approximately $56.3 million Federal share) because we included these payments in another, ongoing review (report number A-02-06-01003);

- identified a universe of 52,723,595 payments totaling approximately $10.7 billion (approximately $5.4 billion Federal share) for services rendered to Medicaid beneficiaries in New York during the 6-month period ended June 30, 2005; and

- selected a simple random sample of 200 payments from the universe of 52,723,595 payments, as detailed in Appendix A.

For each of the 200 sampled items, we determined whether the case file contained sufficient information for the district office to have made a Medicaid eligibility determination on the date of initial determination or redetermination. We also attempted to obtain sufficient independent information to determine whether the beneficiary was eligible for Medicaid on the date of service. Specifically, we determined whether:

- the case file contained a signed application from the beneficiary;
- the beneficiary was assigned to the correct eligibility category;
- the case file contained the beneficiary's Social Security number and, if so, whether the Social Security Administration issued the number to the applicant;
- the beneficiary resided in New York State by checking driver's licenses, rental agreements, or Federal, State, or local government correspondence;
- the beneficiary's identity, including name, age, and citizenship status, in the case file matched the information on file with the New York Bureau of Vital Statistics and the U.S. Citizenship and Immigration Services's Systematic Alien Verification for Entitlement program;
- the beneficiary's income was at or below the income thresholds required to be eligible for Medicaid by reviewing information from the State Wage Information Collection Agency;
- the beneficiary's resources were at or below the resource thresholds required to be eligible for Medicaid by checking New York State's Welfare Management System's Resource File Integration system;[4]
- the case file for blind and/or disabled beneficiaries not receiving SSI contained a physician's report of examination to support a determination of blindness and/or disability;
- the beneficiary met all applicable liability requirements; and
- the beneficiary was eligible for both Medicaid and the service received.

We used an attributes appraisal program to estimate, for the total population of 52,723,595 payments for services rendered to Medicaid beneficiaries, (1) the total number of payments for ineligible beneficiaries and (2) the total number of payments for which documentation did not support eligibility determinations.
We used a variables appraisal program to estimate, for the total population of 52,723,595

[4]The Resource File Integration system, a subsystem of the Welfare Management System, uses Social Security numbers to compare individuals in the Welfare Management System against individuals on the resource files of various State and Federal agencies, including the New York State Department of Taxation and Finance, the New York Department of Labor, and the Social Security Administration.

payments for services rendered to Medicaid beneficiaries, (1) the dollar impact of the improper Federal funding for ineligible beneficiaries and (2) the dollar impact of the payments for which documentation did not support eligibility determinations.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATION

The State agency (1) made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations. Of the 200 payments in our statistical sample, 16 payments totaling $874 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. In addition, for 58 payments totaling $10,699 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required.

As a result, for our 6-month audit period, we estimate that the State agency made 4,217,888 payments totaling $230,375,748 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 15,289,843 payments totaling $2,820,569,979 (Federal share).

ELIGIBILITY ERRORS

The table below summarizes the 16 eligibility errors noted in the sampled payments.

Eligibility Errors and Associated Unallowable Payments

Eligibility Error	Number of Unallowable Payments	Unallowable Federal Payments
Beneficiaries were ineligible:		
Did not meet income requirements on dates of service	6	$378
Did not meet the waiting period for certain qualified aliens	3	154
Did not reapply for continued coverage	2	63
Did not furnish a Social Security number	1	87
Subtotal	**12**	**$682**
Beneficiaries had not met liability requirements	2	$131
Beneficiaries were ineligible for certain services	2	61
Total	**16**	**$874**

Beneficiaries Were Ineligible

Pursuant to 42 CFR part 435, income and resource thresholds are established by the State and must be included in the State plan. Generally, the thresholds vary based upon eligibility category and the number of family members in the household. Federal regulations (42 CFR § 435.916(b)) require the State to have procedures designed to ensure that beneficiaries promptly and accurately report any changes in circumstances that may affect eligibility.

Pursuant to Federal laws restricting welfare and public benefits for aliens (8 U.S.C. §§ 1601-1646), legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Medicaid for the first 5 years after entry.

Pursuant to 42 CFR § 435.916(a), the State must redetermine Medicaid eligibility at least every 12 months. The State agency's "Medicaid Reference Guide" requires that the beneficiary "submit a written renewal (recertification) to continue Medicaid."

Regulations (42 CFR § 435.910(a)) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her Social Security number to the State. If the individual cannot recall or was not issued a Social Security number, the State must assist the individual in obtaining or identifying his or her Social Security number. In cases where an individual refuses to get a Social Security number for "well established religious objections," as defined in 42 CFR § 435.910(h)(2), the State can obtain a Social Security number for the individual or use another unique identifier.

Of the 200 sampled payments, 12 payments totaling $682 (Federal share) were made on behalf of beneficiaries who did not meet eligibility requirements under Federal law and regulations:

- For six payments totaling $378 (Federal share), the beneficiaries' household incomes exceeded the Medicaid income threshold on the dates of service.

- For three payments totaling $154 (Federal share), the beneficiaries did not satisfy the five year waiting period applicable to certain qualified aliens to be eligible for Medicaid.

- For two payments totaling $63 (Federal share), the beneficiaries had not reapplied for continued coverage.

- For one payment totaling $87 (Federal share), the beneficiary did not furnish his or her Social Security number. The case file confirmed that the beneficiary had never applied for a Social Security number and there was no evidence of any religious objections to obtaining a Social Security number.

Beneficiaries Had Not Met Liability Requirements

For the "medically needy" category, Federal regulations (42 CFR § 435.831(d)) require the State to deduct medical expenses incurred by the individual or family from income if countable income exceeds the income threshold. This is called beneficiary liability or spenddown. For example, if

the monthly income threshold in the State is $1,000 and the beneficiary is earning $1,200, the beneficiary must have medical expenses equal to or greater than $200 to qualify for Medicaid. A Medicaid payment is unallowable when these beneficiary liability requirements have not been met, and such payments should be identified as an eligibility error under the State's MEQC program.

For two sampled payments totaling $131 (Federal share), the State agency paid for services rendered to beneficiaries who had countable income above the income threshold on the dates of service and who had not met the beneficiary liability requirements.

Beneficiaries Were Ineligible for Certain Services

Federal regulations (42 CFR § 431.804) define one type of eligibility error as "Medicaid coverage has been authorized or payment has been made for a recipient . . . [who] was eligible for Medicaid but was ineligible for certain services he received. . . ."

Section 369-ee of the New York State Social Services Law provides eligibility and coverage criteria for the FHPlus program. Pursuant to section 369-ee, FHPlus provides comprehensive health insurance to low-income adults aged 19 through 64 who are not pregnant, who have income or resources above the thresholds for the other Medicaid categories, and who do not have other health insurance coverage. Section 369-ee provides that the FHPlus benefit package includes primary, preventive, specialty, and inpatient care provided through managed care plans. Thus, beneficiaries who are eligible only for FHPlus are not eligible for services provided on a fee-for-service basis.

For two sampled payments totaling $61 (Federal share), the State agency provided Medicaid coverage to beneficiaries for specific services not covered under the beneficiaries' eligibility categories. The two payments were fee-for-service payments for beneficiaries with incomes at the dates of service within the requirements for FHPlus but above the thresholds for the other Medicaid categories. Thus, although the two beneficiaries were eligible only for FHPlus, the State agency district office classified the beneficiaries in other coverage categories. Under FHPlus, all health care services are provided through the managed care plan and are not separately billable.

INSUFFICIENT DOCUMENTATION TO SUPPORT ELIGIBILITY DETERMINATIONS

Federal regulations (42 CFR § 435.907(a)) require a written application from each applicant. The regulations (42 CFR §§ 435.911(a) and 435.916(a)) also require the State to (1) determine Medicaid eligibility within 90 days for applicants who apply based on disability and within 45 days for all other applicants and (2) redetermine eligibility at least every 12 months. In addition, the State must include in each applicant's case file facts to support the State's decision on the application (42 CFR § 435.913(a)).

For 58 sampled payments totaling $10,699 (Federal share), the case files did not contain adequate documentation to support eligibility determinations. Each case file was missing at least

one of the following: an application covering the date of service, a signature on the application, and facts supporting income level, fulfillment of beneficiary liability requirements, residence, date of birth, and citizenship status.

CONCLUSION

Of the 200 Medicaid payments in our statistical sample, 16 payments made on behalf of beneficiaries did not comply with Federal and State eligibility requirements. In addition, the State agency made 58 payments on behalf of beneficiaries whose case files did not contain all documentation supporting eligibility determinations as required by Federal requirements.

For the sampled payments, (1) beneficiaries did not always fully disclose information at the time of application or eligibility redetermination and did not always notify the State agency district office of changes in financial situation or other changes affecting eligibility; (2) district offices did not verify all information provided to support beneficiaries' applications; and (3) district offices did not always maintain appropriate documentation to support eligibility determinations.

Extrapolating the results of our sample to the 6-month audit period, we estimate that the State agency made 4,217,888 payments totaling $230,375,748 (Federal share) on behalf of ineligible beneficiaries. Further, we estimate that case file documentation did not adequately support eligibility determinations for an additional 15,289,843 payments totaling $2,820,569,979 (Federal share). (See Appendix B for the details of our sample results and projections.)

We are not recommending recovery primarily because, under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's MEQC program.

RECOMMENDATION

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, the State agency should (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require district office employees to verify eligibility information and maintain appropriate documentation in all case files

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APPENDIXES

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SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine the extent to which the New York State Department of Health (State agency) made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

POPULATION

The population was all payments for services rendered to Medicaid beneficiaries in New York during the 6-month period ended June 30, 2005, excluding payments made for Supplemental Security Income (SSI) beneficiaries, beneficiaries under the Title IV-E foster care and adoption assistance cases, and the State Children's Health Insurance Program (SCHIP) Medicaid expansion.

SAMPLING FRAME

The sampling frame was a computer file containing 52,723,595 payments for services rendered to Medicaid beneficiaries in New York during the 6-month period ended June 30, 2005. The 52,723,595 payments excluded payments made for SSI beneficiaries, beneficiaries under the Title IV-E foster care and adoption assistance cases, and the SCHIP Medicaid expansion. The total Medicaid reimbursement for the 52,723,595 payments was $10,715,127,315 ($5,377,058,250 Federal share).

SAMPLE UNIT

The sampling unit was an individual payment for service rendered to a Medicaid beneficiary during the audit period.

SAMPLE DESIGN

We used a simple random sample to evaluate Medicaid eligibility.

SAMPLE SIZE

We selected a sample size of 200 Medicaid payments.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services (OAS) Statistical Sampling software dated June 2005. We used the Random Number Generator for our simple random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the claims in our sampling frame and selected the random numbers that correlated to the sequential numbers assigned to the claims in the sampling frame. We then created a list of 200 sampled items.

CHARACTERISTICS TO BE MEASURED

We based our determination as to whether each sampled payment was unallowable on Federal and State laws, regulations, and other requirements. Specifically, if at least one of the following characteristics was met, we considered the payment under review unallowable:

- The beneficiary did not meet one or more eligibility requirements.
- The beneficiary had not met liability requirements when authorized for participation in the program.
- The beneficiary was eligible for Medicaid but ineligible for the service rendered.

In addition, we also determined whether the case files contained sufficient documentation to support the eligibility determination as required by Federal regulations.

ESTIMATION METHODOLOGY

We used both the OAS attributes and variables appraisal programs in RAT-STATS to appraise the sample results.

We used the attributes appraisal program to estimate the total number of payments made for Medicaid beneficiaries who did not meet eligibility requirements and the total number of payments for which documentation did not support eligibility determinations. We also used the variable appraisal program to estimate the total amount of Federal payments made for ineligible Medicaid beneficiaries and the total amount of Federal payments for which documentation did not support eligibility determinations.

DRAFT

SAMPLE RESULTS AND PROJECTIONS

ELIGIBILITY ERRORS

The results of our review of the 200 Federal Medicaid payments were as follows:

Sample Results

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Payments	Value of Improper Payments (Federal Share)
52,723,595	$5,377,058,250	200	$26,706	16	$874

Projection of Sample Results
Precision at the 90-Percent Confidence Level

	Attributes Appraisal	Variables Appraisal
Midpoint	4,217,888	$230,375,748
Lower limit	2,679,507	$116,355,444
Upper limit	6,272,615	$344,396,053

DRAFT

APPENDIX B
Page 2 of 2

INSUFFICIENT DOCUMENTATION

The results of our review of the 200 Federal Medicaid payments were as follows:

Sample Results

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Payments With Insufficient Documentation	Value of Payments With Insufficient Documentation (Federal Share)
52,723,595	$5,377,058,250	200	$26,706	58	$10,699

Projection of Sample Results
Precision at the 90-Percent Confidence Level

	Attributes Appraisal	Variables Appraisal
Midpoint	15,289,843	$2,820,569,979
Lower Limit	12,512,778	$1,545,965,763
Upper Limit	18,316,064	$4,095,174,195

Rec'd
JUL 25 2006

National Health Policy Group

Improving Payment and Performance for High-Risk Beneficiaries

July 25, 2006

WAITING FOR
MAILED COPY

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development -A
7500 Security Boulevard
Room C4-26-05
Baltimore, MD 21244

RE: Agency Information Collection Activities: Proposed Collection; Comment Request CMS-10194: Comments on SNP Mail Survey and Moderator Guide for Beneficiary Focus Groups

ATTENTION: Melissa Musotto

Dear Ms. Sirs:

The National Alliance of Specialty Healthcare Programs (SNP Alliance) appreciates the opportunity to comment on survey instruments that will be used as part of the SNP evaluation for the Report to Congress required by the Medicare Modernization Act. We are attaching specific comments on the SNP Mail Survey that we understand will be distributed to all Special Needs Plans (Attachment A) and the Draft Moderator Guide for Beneficiary Focus Groups that will be conducted at a limited number of plans that are participating in SNP site visits (Attachment B). Below is a summary of key findings from the SNP Alliance Medical Director Work Group regarding both instruments. We look forward to discussing our comments further with CMS and MPR staff prior following the submission of comments

SNP MAIL SURVEY

We support the overall direction of the SNP Mail Survey and believe that it will produce important profiling information about SNPs. We have several suggestions regarding the data collection instruments that we believe will ensure that there is a uniform data collection period; a common understanding among plans regarding the questions and data requested; comparability in the type of information provided to CMS and a greater ability to differentiate among plans in areas such as care management, special services and clinical programs and approaches; risk sharing arrangements; provider contracting; and other areas where SNPs are likely to look or operate differently than a standard MA program. Toward this end, we recommend the following:

- Send the survey to the government relations/programs department and the plan compliance officer and advise them to identify which plan staff are best suited to respond to various parts of the survey.
- Direct plans to respond to the survey for the 2006 SNP contract year to produce the largest number of responses for a single contract year. Coordinate other plan data such as bidding and RAPS data with the 2006 contract year to ensure consistency in analyzing risk/benefit/cost analyses.

- Clarify intent of inquiry on patient distribution by size of group practice and modify to produce uniform responses across plans.
- Provide an opportunity for more open-ended responses regarding risk-sharing arrangements to allow SNPs to catalogue more fully the array of risk sharing strategies, better differentiate SNP risk sharing arrangements from standard MA plans and better understand the type of risk-sharing employed to produce specific outcomes.
- Section C on enrollment and target marketing has multiple response options with no structure for ranking or prioritization. Some type of ranking or metric should be included to allow CMS to scale methods within and across plans.

- Section D on special services offers an important opportunity to help CMS evaluate differences between standard MA plan and SNP clinical approaches to serving high risk beneficiaries. Several changes are critical to achieving this goal:
  - ✓ Care coordination (CC), case management (CM) and disease management (DM) functions are not differentiated. CMS should define these terms or ask plans to define.
  - ✓ Plans should respond to inquiries about lead health professionals responsibilities and specific care activities (managing transitions, health education, etc.) in relation to the three key functions identified (CC, CM, DM).
  - ✓ Plans should document FTEs by CC, CM and DM functions and CMS should add a question about percentage of special needs beneficiaries receiving these services.
  - ✓ CMS should consider including a basic list of services offered by SNPs to meet special needs in addition to CC, CM and DM (i.e., home care, medical transportation, specialty pharmacy management, AODA services, etc.).

- We recommend greater specificity for outcomes data; i.e., hospitalization rates for *ambulatory care sensitive conditions*. We also recommend adding additional categories that are unique to high-risk populations such as medication errors and nursing home admissions rates.

- Sections F and G relating to the dually eligible population should not be limited to dual SNPs. All SNPs serve dually eligible beneficiaries should respond to dual questions. Also, questions about special needs and services should be included for all 3 SNPs, not just duals.

- We recommend adding some questions in Section G on barriers to integrating Medicare and Medicaid benefits and on the impact of Part D cost-sharing rules for duals on access to needed drugs and access to other supplemental benefits.

MODERATOR GUIDE FOR BENEFICIARY FOCUS GROUPS

- We recommend giving a series of examples about what triggered enrollment in the SNP; i.e., attempting to meet a specific health need, physician recommendation, advice of a trusted advisor, better pharmacy benefits, etc.

- We recommend adding a question about whether the beneficiaries ever participated in a Medicare Advantage plan before as a benchmark for evaluating their SNP experience.

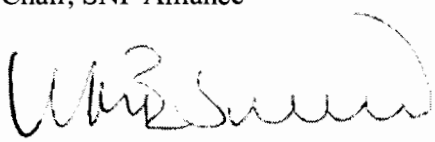
- We recommend adding more questions about the special needs of targeted populations to determine if plans are doing a better job with polypharmacy management, comorbidity management, care management and other needs unique to a SNP population.

- We recommend differentiating between direct services like dental or personal care and management functions like care management and disease management in Section D on awareness and use of plan benefits since beneficiaries may not perceive management functions to be a special service, nor are beneficiaries necessarily equipped to accurately rate t his type of function.

We would be happy to answer any questions you may have about our suggestions and recommendations and to help further refine these survey instruments to ensure the most effective responses from Special Needs Plans. Please do not hesitate to contact us if we can help in any way.

Sincerely,

Richard J. Bringewatt
President, NHPG
Chair, SNP Alliance



Valerie S. Wilbur
Vice-President, NHPG
Co-Chair, SNP Alliance

801 Pennsylvania Avenue, Suite 245, NW, Washington DC 20004
(202) 624-1508 Fax: (202) 737-6462

Attachment A

Comments on SNP Mail Survey

SURVEY ADMINISTRATION

1. Please identify who the survey will be sent to at the health plan. We recommend sending it to the government relations/programs division and SNP compliance officer as they should be best equipped to identify which staff or departments are best suited to filling out various components of the survey related to provider arrangements, risk-sharing, enrollment, special services, etc.

2. Some MAOs are sponsoring dozens of SNPs in different parts of the country. For example, as of January, United Healthcare and Wellcare each sponsored upwards of 70 or more SNPs. We recommend that CMS identify a strategy for these organizations to respond on behalf of the many plans they sponsor instead of sending a survey to literally every plan. For example, it may be more appropriate for these organizations to fill out some type of grid that shows the range of benefits, provider contracting arrangements, risk-sharing arrangements and other information requested by CMS. This would ensure that CMS understands the overall direction of the company and the range of products they are offering without requiring them to duplicate the survey at the plan level for dozens of plans. We request the opportunity to work with CMS, MPR and Evercare to identify a strategy that provides CMS the information they need while minimizing undue data burden on MAOs like United.

3. The survey does not direct SNPs to provide responses for a particular year. We recommend that CMS request data for 2006 to ensure the largest number of responses for a single year. We also recommend that bid data, risk scores and other information used for the evaluation be collected for the 2006 contract year so that benefits, bid data, risk sharing arrangements and other related information is evaluated as part of the overall plan design for a given year.

4. The Instructions do not indicate when surveys need to be returned. A target date should be included.

SECTION A: ORGANIZATION

A2, A6 and A10: Type of SNP: Include two categories for each of the 3 SNP categories– plans *exclusively* serving institutional, dual or chronic condition beneficiaries and plans *disproportionately* serving these three categories. In addition, please add appropriate subsets of these key SNP categories consistent with CMS' impending decision to allow SNPs to serve subsets that are consistent with state dual policy.

A3: Enrollment Restrictions: Given the number of plans from dual demonstrations participating in this survey, we suggest that the following additional eligibility categories be added:

- seniors
- adults with disabilities
- nursing home certifiable beneficiaries
- dual subsets

SECTION B: PROVIDER ARRANGEMENTS

B1: Distribution of Beneficiaries by Practice Setting

- What is the intent of asking the question about percentage of members served by various sized practices? How does the size of the medical practices serving SNPs inform CMS' understanding of SNPs?
- What is meant by "independent practice"? Does this mean an individual physician or sole practitioner?
- Some plans will not be able to answer this question easily or it will take a lot of work to break down the data to give an accurate response. For example, some plans contract with IPAs that have small, medium and large group practices *affiliated with a single IPA*. For plans that contract with several IPAs, with multiple group sizes and types, it will be a complicated process to calculate the percentages of members affiliated with various sized groups across multiple IPAs and group practices. To the extent that plans have to interpret how to respond to this question, it will reduce the likelihood of a uniform response across plans. To help ensure a uniform response, it would be helpful to better understand the nature of the inquiry.

B3: Describe Risk Sharing Arrangements. SNP Alliance members indicated this is a complicated question that cannot simply be answered with a "full versus partial risk" response. Some plans are likely to have multiple risk sharing arrangements and would need to have a chart for each type of provider to fully catalogue the range of risk sharing relationships. There are different levels of risk between plans and IPAs, IPAs and physicians, plans and physicians, etc. that would not be captured by the response options.

We suggest the following options for enhancing responses to this question:

- Start out with key questions about financial incentives and outcomes:
  - ✓ Are your SNP provider relationships different from your current or historic relationships under "standard" managed care plans?
  - ✓ How did you structure your risk-sharing relationships to produce specific clinical and/or financial outcomes?

- In the box of definitions of risk levels, add another category called "other" and ask plans to describe on a separate sheet.
- Restructure the chart to allow plans to identify multiple risk-sharing relationships for each provider category and indicate they should provide additional detail needed on a separate sheet.
- Eliminate chart and include open ended question asking plans to describe the range of risk sharing relationships and ask them to rank in some way to indicate most and least prevalent contract types.

B8: Add a new question: What impact does Part D exclusions have on special needs plans beneficiaries? (e.g., over the counter drugs, benzodiazepines needed by disabled adults, etc.)

SECTION C: ENROLLMENT

C2: Target Marketing: This questions needs to be rank ordered to provide a meaningful response. We expect that many plans would check multiple boxes and CMS would not be able to determine which form of targeting is primary for each plan. We recommend:

- Directing plans to rank order identification methods from most to least prevalent or to use some other metric such as percentage of enrollment from various sources.

- Ranking the 4 different identification methods included in question C2(1)

- Dividing C2 (2) into 2 separate questions (passive enrollment vs. marketing to other MAO plans) so that CMS can specifically track the number of dual beneficiaries enrolled via passive enrollment. The Alliance believes it is very important to be able to compare "passive enrollment" plans with other plans on a number of levels and to track the experience and evolution of these plans over time.

SECTION D: SERVICES FOR MEMBERS WITH SPECIAL NEEDS

This section of the survey is most relevant to clinical programs and services and should tell CMS how SNPs are different from "standard" MA plans and what special approaches and interventions they will employ to address the special needs of their targeted high-risk population. The issues being addressed are extremely important and warrant greater clarification so that the data produced tells a meaningful story. Below are some specific suggestions for enhancing the data collected from this section of the survey and CMS' ability to evaluate the output.

D1. Identifying Enrollees Needing Special Services. Most plans are likely to use multiple forms for identifying members who need special services. It would be helpful to further differentiate the responses to these options. For example, screening or assessment instruments may be administered at enrollment OR based on some other trigger identified by the plan. It would be more informative to ask plans to identify when screening surveys and clinical assessments are used; what type of instruments are used; who administers the surveys/assessments (nurse, social worker, therapist); whether the surveys are mail or telephone surveys, etc. Also, it is likely they would use different methods for different functions—they might use one type of screening for disease management and another type for medical case management or they might use screens to determine if the person needs disease management vs. complex care management.

D2. Member Management Functions. Care coordination, case management, care management, disease management are often used interchangeably. This line of questioning is much too important to leave open ended. We recommend that CMS either offer a generally accepted definition of each function or ask the plans to define these functions in their own terms so that the responses are aggregated on an apples- to-apples basis across plans. Then, eliminate question D4 which asks what the plan calls the service.

D3: Meeting Special Needs. We recommend including some options for plans to select relative to helping beneficiaries "get those needs met." For example:

a. Plan provides/arranges access to the following special services (check all that apply):
   - Specialty Pharmacy Management (ask plan to define)
   - Wound Care
   - Home and Community-Based Waiver Services
   - Medical Transportation
   - Fall Clinics
   - AODA programs
   - Other (ask plan to describe)

D5. Lead Health Professionals by Management Function. The type of health professional responsible for care coordination, case management and disease management is likely to vary according to the function. For example, social workers might do DM and advance practice nurses might do case management. We suggest a chart to better differentiate these functions:

D6: Staffing Ratios for Management Functions. FTEs should be identified for specific populations and functions; e.g., plans may need more FTEs per caseload for case management than disease

management. In addition, disproportionate SNPs should report the FTEs for the SNP target population, not across all plan enrollees. We also recommend that CMS ask plans to identify the percentage of beneficiaries that receive care coordination, case management and/or disease management. We recommend using a chart to collect these statistics.

Function	Components (Describe)	% Receiving	FTEs	Accountable Party					
				PCP	APN	RN	LPN	Social Work	Ther-apist
Care Coordination									
Case Management									
Disease Management									

D7: Primary Responsibilities: It would be helpful to better differentiate these functions by staff. Which staff are responsible for which tasks (e.g., managing transitions between care settings) and in relation to which functions (e.g., care coordination versus disease management). It also would be helpful to prioritize these tasks in relation to function. For example, health education is likely to be a principle function for disease management but may be less relevant to complex medical management. Also, monitoring, health education and other activities may be part of the three key "management functions" but the activities may vary by function as well as who carries out the activities.

We also recommend adding an additional item under D7 related to "serving as liaison to family members"

SECTION E: USE OF TECHNOLOGY:

General Points:

- SNP Alliance Medical Directors recommended clarifying the locus of use for the technology, e.g., physician office use vs. care management staff monitoring of community-based enrollees.

- **New:** Add a new question to identify whether multiple providers have access to the same medical record and, if so, which providers.

E9: Care Process Data. We recommend adding several process of care measures related to complex chronic care management such as asking plans to identify if they monitor continuity of care, safe and effective care transitions, adverse drug interactions, etc. and if so, what specific process measures they use. We recommend using the SNP Alliance Quality Domains for further guidance in this area (Attachment C).

E11: **Outcomes Data**: We recommend greater specificity on outcomes data:

- hospitalization *and* rehospitalization rates for ambulatory care sensitive conditions,
- ER visits for ambulatory care sensitive conditions
- Nursing home admission rates for nursing home certifiable beneficiaries
- Medication errors
- Proxies for frailty; e.g.
    - ✓ ADL/IADL impairments

- ✓ Weight loss
- ✓ Gait speed or other endurance measures

SECTION F: DUAL ELIGIBLES

General: This section should not be limited to Dual SNPs. All SNPs serve dual eligibles and all SNPs should fill out this section.

F1, 2, 3: Special Needs. These sections should not be limited to dual SNPs. CMS should collect similar data for all three SNP categories. Question F1 should be repeated for institutional SNPs and for SNPs serving those with severe or disabling chronic conditions. Follow up questions should be included on the most important special needs (F2) and how the plan intends to address the special needs (F3) for the institutionalized and chronically ill, not just for duals.

SECTION G: DUAL SNPS WITH MEDICARE AND MEDICAID MANAGED CARE CONTRACTS

General:

- This section should apply to all SNPs that have Medicare and Medicaid managed care contracts, not just dual SNPs.
- New questions should be added:
  - ✓ Is your plan be interested in pursuing an integrated approach to financing and oversight for Medicare and Medicaid services?
  - ✓ What do you see as the greatest barriers to financial integration?
  - ✓ What do you see as the greatest barriers to administrative integration?
  - ✓ Has Pt. D cost-sharing affected your beneficiaries' access to needed medications or compliance with prescribed drug regimens?
  - ✓ Did your pharmacies waive the cost-sharing at point of service for duals that could not pay the $1 and $3 copays?
  - ✓ Did your plan reduce supplemental benefits in order to allocate more rebate dollars to the Part D benefit?
  - ✓ Was your plan premium covered by the low-income drug subsidy?

Attachment B

Moderator Guide for Beneficiary Focus Groups

SECTION B: PARTICIPATION AND AWARENESS OF PLAN MEMBERSHIP

- Add a question about whether beneficiaries were previously enrolled in a Medicare Advantage plan as a benchmark against which to evaluate their expectations about differences in SNP services and their response to satisfaction with SNP special services.

SECTION C: DECISION TO PARTCIPATE

- **Question 4:** Why did you enroll? We think it would be helpful to identify some examples of why people may have enrolled to help evaluate the importance of specialized services to their decision; e.g.: enrollment was triggered by:
  - ✓ Special services offered
  - ✓ Recommendation of a trusted physician
  - ✓ Recommendation of a family member or trusted adviser
  - ✓ General affiliation with enrollee's medical group or hospital
  - ✓ Geographic location
  - ✓ Superior drug benefit
  - ✓ Desire to meet specific special need – ESRD, CHF, general frailty or overall medical complexity

SECTION D: AWARENESS AND USE OF PLAN BENEFITS

Below are some comments on the questions in Section D. Please note that in some cases we are recommending edits to questions with specific language proposed. In these cases, we underline the words or phrases we recommend adding.

Question 3: Which of these special services have you used? Did a social worker, nurse practitioner or nurse help you access these services? Did a nurse, social worker or nurse practitioner provide you with extra help?

Question 4: Have you tried to use any of these services but were unable to do so? Has the plan provided extra help for you with your medical concerns? What happened?

Question 5: This question may offer insights into care coordination or care management functions performed by plan, but should not be not seen as an expectation, or indicator of quality.

Questions 3, 4 and 5 will offer insights into a plan's "management functions" -- care coordination, care/case management, and disease management. We think it would be a good idea, however, to separate questions on "special services" like dental or personal care from questions on the management functions. We think it would be useful to add a few specific questions about care management, care coordination and disease management and perhaps ask beneficiaries if they are familiar with these terms and what they mean (see underlined questions below). The list of services under question 2 are "direct" or hands-on services that people can "see and feel." The "management" services are about identifying need, evaluating options, arranging access to services, monitoring treatment plans and outcomes, etc. We think these services might not be as apparent to beneficiaries or considered "special services" to them. We have found in talking to a number of demos that it isn't necessarily the care management functions that professionals value that attract a consumer to these demos – but rather it's the services they can see and feel (e.g., personal care, generous pharmacy benefits, etc.). The value of "management" services can't be

very well or completely assessed by the recipient, since the goal is not to "please" that person, but to provide better care. But we think it is important to understand what beneficiaries are aware of receiving from a plan and, ideally, whether they note a difference from prior experiences.

New Questions on Care Coordination/Management and Disease Management:

- Do you know who your care manager is and how to contact this individual if you have a problem?
- Did your plan evaluate your health care problems?
- Did they tell you what kind of services were available to help with your health conditions or concerns?
- Did they help arrange these services for you?
- Does your plan call you routinely to monitor a particular health care condition like diabetes or heart disease?

Question 6: What types of plan services do you use most? What services do you value most? Has the plan improved your health care? How?

SECTION E: SATISFACTION WITH PLAN BENEFITS

- **Question 2: Comparing SNP Care to Prior Experience:** We recommend defining "preventive care" and adding questions that are more targeted to the special needs of enrollees; e.g.:
  - ✓ Are the services more responsive to a specific condition or disease?
  - ✓ Do the plan and its providers do a better job coordinating care among all your different doctors and providers and helping you manage your prescription drugs?
  - ✓ Are the disease management or care management services different from those received from previous health plans?
  - ✓ Do you receive care from different types of professionals?
  - ✓ Does the plan promote greater involvement of your loved ones in meeting your care needs?
  - ✓ How does your overall experience with this plan differ from other Medicare plans or when you received original Medicare benefits?

Attachment C

Proposed Domains and Quality Indicators for Special Needs Plans

"The goal of medical care for the elderly has progressed beyond survival to maximizing quality of life, yet little attention has been paid to the overall quality of medical care that older people receive. In fact, existing measures of quality or health status are often inappropriate for the elderly."

Rand Health

The Medicare Modernization Act of 2003 established Medicare Advantage Special Needs Plans (SNPs) to serve high-risk beneficiaries including those who are permanently institutionalized, dually eligible for Medicare and Medicaid and those with severe or disabling chronic conditions. The quality domains listed below were identified by the National Alliance of Specialty Healthcare Programs through a consensus process based on the experience of medical directors of plans specializing in programs for frail elders and adults with disabilities. Each domain includes a brief goal statement and recommended quality indicators related to the goals. These measures are intended as a framework for performance measurement that more appropriately reflects the health care needs of vulnerable, high-risk beneficiaries with multiple chronic conditions and complex medical problems.

1. **End of life care**: To enhance comfort and improve the quality of an individual's life during the last phase of life.

   Preliminary Quality Indicators:
   - *Comprehensive advanced care planning is carried out, with evidence that:*
     - ✓ *advance directives have been reviewed and signed;*
     - ✓ *conditions, trajectory of diseases and treatment options have been discussed;*
     - ✓ *treatment and care plans are modified as conditions evolve or circumstances change.*
   - *Palliative care is provided in setting of choice.*
   - *A comprehensive palliative care plan is developed that includes, but is not limited to, pain management, symptom control and access to appropriate supportive services.*

2. **Continuity of care**: To ensure coherent, consistent and connected collective performance among patients and family caregivers and primary, acute and long-term care providers in addressing the needs and interests of individuals as their conditions evolve over time and across care settings.

   Preliminary Quality Indicators:

   - *An identified individual health professional or team member with primary responsibility for care management/care coordination across settings.*
   - *Demonstrated evidence of interdisciplinary care teams and collaboration.*
   - *Individual care plan shared by all care providers involved in the patient's care.*
   - *The ability of the beneficiary or his/her family caregiver to identify and name their primary care manager, or contact, and know how to access them.*

3. **Safe and effective care transitions**: To ensure that people move safely and easily from one place to another, from one level of care to another, and/or from one health care practitioner to another.

   Preliminary Quality Indicators:
   - *A member of the health care team sees or communicates with the patient or informal caregiver within 72 hours of discharge to a new care setting.*
   - *A review of patient medications will be conducted within 24 hours of discharge.*
   - *A member of the health care team facilitates communication between providers in a timely manner to ensure safe and effective care transitions.*
   - *If a member is discharged from a hospital to home and has received a new prescription medication or a change in medication before discharge, then the outpatient medical record should acknowledge the medication change in a timely manner.*
   - *If a member is transferred between emergency departments, acute care facilities, and/or long-term care facilities, or from one of these entities to another, then the medical record at the receiving facility should include medical records from the transferring facility or should acknowledge transfer of such medical records.*

4. **Functional independence**: To optimize the ability to perform self-care, self-maintenance and physical activity, including addressing issues of disability, impairment, and/or frailty.

   Preliminary Quality Indicators:
   - *Plans screen all members to identify risk of impairment in physical and cognitive functioning and have triggers in place regarding the need for comprehensive assessments.*
   - *Health plans have policies for timing of assessments of physical and cognitive functioning which include appropriate triggers for reassessment.*
   - *Health plans have capacity to conduct home safety evaluations in relation to physical functioning and triggers for when such assessments are appropriate.*
   - *Health plans have a process for maximizing functional independence.*

5. **Member choice and quality**: to ensure consumer satisfaction as measured by consumer defined goals.

   Preliminary Quality Indicators:
   - *To ensure that individual care plans include consumer-defined goals, beneficiaries and/or their caregivers participate in the development of their treatment goals and care plans.*
   - *An annual assessment of member and caregiver satisfaction is conducted.*

6. **Medication management**; to optimize compliance and drug performance and minimize adverse drug events, with particular regard for polypharmacy issues.

   Preliminary Quality Indicators:
   - *Health plans conduct an initial assessment of overuse, underuse, and inappropriate use of medications, reassess medication management at least annually and have triggers for conducting reassessments at other times, as appropriate.*
   - *Health plans have a system in place to track and address medication errors.*
   - *Health plans have a process for identifying and addressing non-compliance with medications.*
   - *Principal care team, all physicians' outpatient records and hospital medical records should have current record of all patient medication.*
   - *Health plans have a process for monitoring adverse drug events and the effects of polypharmacy.*

7. **Population Specific Medical Conditions**: to effectively manage falls, incontinence, dementia/delirium, incontinence, pain, pressure ulcers, osteoporosis, and other syndromes unique to special needs beneficiaries.

Preliminary Quality Indicators:

- *Health plans have a process for:*
  - ✓ *monitoring and identifying population-specific medical conditions for high-risk populations, with a focus on disease and disability prevention;*
  - ✓ *assessing and stratifying risk levels and developing appropriate interventions for disease and condition management relative to risk -- from patient education to aggressive treatment plans; and*
  - ✓ *evaluating outcomes of high-risk screening and assessment and treatment protocol and employing continuous quality improvement approaches to further enhance outcomes.*
- *All persons 75 or older and those at risk of falls should have documentation that they were asked at least annually about the occurrence of falls and treated for related risks, as appropriate (ACOVE).*
- *All females age 75 and older and those at risk of osteoporosis should be counseled about osteoporosis risk and pharmacologic prevention at least once.*
- *"Health plans should develop and/or implement population-specific preventive and treatment guidelines"*

8. **Management of multiple and/or co-morbid conditions:** to develop a multidimensional, integrated approach to medical and health care management, including special tools and the integration and adaptation of disease-specific guidelines, to address the interactive effects of multiple chronic conditions and associated health-related challenges of serving people with serious chronic conditions such as complex diabetes, hypertension, congestive heart failure, asthma, chronic lung disease, chronic depression, chronic renal failure, spinal cord injury, multiple sclerosis, fibromyalgia, and cerebral palsy.

Preliminary Quality Indicators:

- *Health plans account for the presence of comorbidities during the screening and assessment processes.*
- *Health plans adapt evidence-based guidelines and best practices for individual diseases in relation age, comorbid conditions, functional limitations, member goals and preferences and other variables affecting special needs beneficiaries' ability and/or willingness to respond to traditional clinical protocols and approaches.*
- *Health plans develop individual care plans that account for comorbid conditions and other factors that affect traditional treatment approaches.*

9. **Mental illness/behavioral**: to optimize a person's health and well being, with recognition of chronic depression, Alzheimer's disease, schizophrenia, AODA and other mental illnesses as a primary and/or as a co-morbid condition in addressing other acute and/or chronic conditions.

Preliminary Quality Indicators:

- *Plans have a system in place to identify members at risk for behavioral health issues and have triggers in place regarding the need and timing for comprehensive assessments and re-assessments*
- *Appropriate members of the health care team conducts a comprehensive assessment of a member's behavioral health issues and integrates findings into the individual's plan of care.*
- *Health plans develop and implement appropriate protocols and programs for effective behavioral health management and integrate health and behavioral interventions into beneficiary care plans.*

10. ***Family Caregiver Support**: to recognize the critical role of family caregivers as part of the care team, integrate their support into member care planning and provide support and education that enhances their effectiveness as part of the care team. (Added to the prior list of indicators.)*

Preliminary Quality Indicators

- *Health plans have a process for:*
  - ✓ *HIPAA-compliant routine communication with family and informal caregivers;*
  - ✓ *including them in the care planning process, consistent with patient capabilities and preferences;*
  - ✓ *assessing the needs of the family/ informal caregiver; and*
  - ✓ *providing family/informal caregivers the type of education, training and support they need to be an effective part of the informal caregiving team.*
- *Members of the health care team spend adequate time with patients, treat them with respect and explain information to members and their informal caregivers in a manner that is understandable to them.*

STATE OF ALASKA
DEPT. of HEALTH and SOCIAL SERVICES
DIVISION of PUBLIC ASSISTANCE

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July 25, 2006

WAITING FOR
MAILED COPY

Michelle Shortt, Director
Regulations Development Group
CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – A
7500 Security Boulevard
Baltimore, MD 21244-1850

Rec'd
JUL 25 2006

Attention: Melissa Musotto, Room C4-26-05

Dear Mr. Shortt:

Thank you for the opportunity to provide comments on the PERM eligibility proposed rules published on May 26, 2006, page 30410 of the Federal Register, Vol. 71, No. 102. The formal notice of rulemaking and supporting guidance still lacks sufficient detail for states to plan effectively for the PERM.requirements. As presented, the proposed information collection activities appear to leave important procedural questions unanswered. The following comments address the Supporting Statement: Eligibility Error Rate Measurement in the Medicaid and the State Children's Health Insurance Program found as a document in file CMS 10184 on the CMS website.

The comments in APHSA Executive Director, Jerry Friedman's July 2006 letter provide an excellent discussion of the issues of concern to Alaska and other states. For our state there are three particularly serious concerns that we would like to address in our comments to the PERM regulations – sample size, logistics and face-to-face interviews.

Sample Sizes

The sample sizes for all states, regardless of population size, are the same: 200 negatives and 501 active cases for both Medicaid and SCHIP. The Supporting Statement offers no rationale for how these numbers were derived. It would seem that a smaller sample size should be required for a small population state such as Alaska. The proposed methodology creates inequitable requirements, and excessive work burden on small states. The number of Medicaid recipient households in Alaska is relatively small. It is a fraction of that in larger states, yet we are being asked to commit the same level of resources to PERM as states with populations up to 50 times greater than ours.

The proposed active and negative sample sizes present less impact for large states with more staff resources, while in small population states it is a far more significant issue. If a large state must do 501 active reviews annually per program, then a small state should be required to review far fewer cases. To satisfy the Improper Payments Information Act, the statistical validity need only be at the national level so statistical

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

Logistics

The first bullet, 4th paragraph of the Background Section in the Supporting Statement, mandates that states "[r]eview eligibility in the same year the states are selected for Medicaid or SCHIP FFS and managed care reviews." However, throughout the rest of the document, there are consistent references to 17 states doing SCHIP eligibility and another 17 states doing Medicaid eligibility each year. It is hoped that this is an assurance that no one state will be subjected to both Medicaid and SCHIP claims reviews and, consequently, eligibility reviews in the same year. If eligibility reviews are required for both groups in the same year, states will face significant staffing challenges. The burden for states to acquire and train the necessary staff and to operate the program one year out of three is challenging, especially for smaller states.

Face-to-Face Interviews

The PERM regulations published August 27, 2004, state that a face-to-face interview with the beneficiary is optional but must be conducted for any claim where eligibility at the date of service could not be verified through the desk review and field investigation. The Supporting Statement states that CMS has worked to make the active case review requirements less stringent by minimizing the verification requirements, allowing for certain case exclusions from the universe and providing that the states can cite cases where eligibility cannot be determined as "undetermined". It is unclear from the regulations and the Supporting Statement what these minimized verification requirements are and how they apply to the issue of face-to-face interviews. We request that CMS incorporate language to specify situations in which travel can be waived and that eligibility for such cases can be considered "undetermined".

Alaska has remote rural areas in which travel is impractical, dangerous or cost prohibitive. Roughly a third of our public assistance clientele reside in rural areas without connecting road systems. Many communities where Medicaid recipients live lack paved airport runways, commercial lodging, or during portions of the year drivable roads or navigable rivers. The high cost and travel days required to get to some remote areas, such as St. Lawrence Island on the Bering Sea, render face-to-face visits impractical. A single QC home visit could require two to three days of travel for a case reviewer. The USDA, Food and Nutrition Service, which has for years required Food Stamp Program quality control procedures, recognized the unreasonable cost, physical hazard and limited value of rural QC home visits and allowed Alaska to waive the face-to-face interviews, and if necessary, consider the cases "undetermined" in such circumstances.

If you have questions, wish further clarification of our comments or we can provide further recommendations, please contact Mary Riggen-Ver, Quality Assessment Program Officer in the Division of Public Assistance at (907) 465-4952, by e-mail at: mary_riggen-ver@health.state.ak.us or at the above address.

Sincerely,

Ellie Fitzjarrald

Ellie Fitzjarrald, Acting Director

cc:

Jim Dalman, Chief, Program Integrity & Analysis
Mary Riggen-Ver, Quality Assessment Program Officer
Jerry Fuller, Project Director, Office of Program Review

Rec'd [redacted]
JUL 25 2006

July 25, 2006

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Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Melissa Musotto
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Agency Information Collection Activities: Proposed Collection – Payment Error Rate Measurement of Eligibility in Medicaid and the State Children's Health Insurance Program (SCHIP)

To whom it may concern:

Thank you for this opportunity to comment on the "Payment Error Rate Measurement of Eligibility in Medicaid and the State Children's Health Insurance Program (SCHIP)" CMS notice of proposed information collection, published by CMS in the May 26, 2006, edition of the *Federal Register*.

The State of Washington is pleased that CMS has addressed a number of issues and concerns raised in previous comments, and that CMS has consulted with some states regarding eligibility review issues for the PERM project. However, as outlined below, the State is concerned with some of the components of the eligibility error rate measurement program as outlined in the supporting statement.

A. Background (Supporting Statement)

- CMS should make the eligibility workgroup's recommendations public.

  We appreciate that CMS consulted with states, and that CMS accepted many of the workgroup's recommendations. We would request that CMS make the workgroups' recommendations public, so that the states could know what issues have been discussed and accepted and, where possible, the rationale for decisions in relation to the recommendations.

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

  We question the CMS' rationale and authority to implement a state-level error rate. The Improper Payments Information Act (IPIA) of 2002 does not require state-level error

rates and previous PAM/PERM pilots have clearly demonstrated a negative return on investment.

- We request clarification and additional guidance concerning the development and submission of a sampling plan, monthly samples, and sample lists.

B. Justification (Supporting Statement)

- There is insufficient detail explaining the conditions by which MEQC can be substituted for, or satisfy the requirements of, PERM eligibility reviews.

  Washington appreciates CMS' concern about and efforts to mitigate duplication of effort by the PERM eligibility review activities and those of Medicaid Eligibility Quality Control staff. We request clarification of conditions by which traditional MEQC eligibility reviews can be substituted for, or satisfy the requirements for PERM eligibility reviews.

- There is insufficient detail explaining the allowability of "pilot" MEQC reviews to satisfy the requirements for PERM eligibility reviews.

  Will "traditional" states only be approved to conduct PERM eligibility reviews, or will "pilot" states be allowed sufficient flexibility to conduct a "traditional" project for the purpose of PERM eligibility reviews? Washington recommends pilot states be given sufficient flexibility for MEQC staff to conduct traditional PERM eligibility reviews as part of its regular series of eligibility projects.

- There is insufficient detail explaining the necessity for, and detail required, for the monthly sample lists.

  Will "monthly sample lists" of cases selected for eligibility reviews become a case-tracking system for PERM eligibility reviews? Is there a particular format or template CMS would require or recommend?

- There is insufficient detail explaining the structure and function of the corrective action plan.

  Will corrective action plans require CMS approval? Will CMS monitor the implementation and results of corrective action plans? CMS has previously made verbal statements that PERM reviews will not result in penalties. The supporting statement should document this.

- The Burden Estimate does not address all the necessary functions of a PERM project.

There is no mention or resource estimate for a PERM project manager or project coordinator. Washington's experience was that a coordinator of staff and activities was of critical importance to the success of the PAM and PERM projects. Based on experience with the PAM and PERM projects, Washington recommends the Burden Estimate be increased by 800 hours to cover project coordination activities.

- Substantial costs for eligibility reviews can be avoided by modifying eligibility review requirements.

  Costs of conducting full eligibility reviews for the PERM project represents a substantial financial burden that is not required under the provisions of the IPIA of 2002, and will generate minimal recoveries to offset costs. The most expensive component of a full eligibility review is the in-person recipient interview, required by 42 CFR 431.812. Washington recommends CMS make the requirement for in-person recipient interviews discretionary to control PERM costs.

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

  Since the eligibility review portion of the PERM project exists solely to meet the requirement that CMS produce a national error rate, CMS should fund the increased workload at 100%. In PAM Year 3, Washington calculated an eligibility error rate of 1.14% and an approximate Return on Investment of 1 cent for every project dollar spent. Project dollars could be more wisely spent on medical services for clients.

- There is insufficient detail and explanation of sample size development.

  Washington seeks clarification and the statistical particulars of the calculations leading to sample sizes of 501 active cases, and 200 negative cases. We have not been able to successfully replicate any of the calculations regarding sample size and stratification, given the estimated error rate and precision requirements noted in the supporting statement. In addition, we are concerned that the sampling methodology does not consider the population size of individual states. The size of the sample should correspond with the size of the state. We request that the methodologies used in these recommendations be fully explicated and communicated to participating states.

- There is insufficient explanation of the frequency of PERM Projects.

  It was unclear in previous PERM communications that PERM projects would occur in 2 out of every 3 year cycle. Assuming we are interpreting the supporting statement correctly, then eligibility reviews will also occur in 2 out of every 3 year cycle. Washington would like assurance that we will not be required to perform both Medicaid and SCHIP eligibility reviews within the same year. We further recommend CMS quickly communicates to all states the PERM project frequency.

- There is insufficient detail concerning the disposition of undetermined cases.

  The supporting statement indicates states will identify the number of cases and payment amounts for undetermined cases (cases where eligibility could not be determined), but makes no statement regarding return of payments in these cases, nor guidance regarding inclusion in error rates. Washington requests clarification and recommends that since the cases are undetermined, that no reimbursement or cost-recovery efforts be undertaken for those cases.

- The procedures for SCHIP eligibility review are not given.

  The supporting statement references the SCHIP eligibility review requirements in 42 CFR 457, subpart I, which 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. Washington requests that CMS develop a compendium of specific eligibility review procedures for SCHIP eligibility determination. Guidance and guidelines on SCHIP eligibility reviews would provide greater consistency between states, and afford CMS greater confidence in determining an SCHIP national eligibility error rate.

Thank you for the opportunity to comment and make recommendations related to the proposed PERM regulations. We welcome the opportunity to participate in further discussions with CMS and our fellow states about the PERM program methodology and design.

Sincerely,

Bob Covington, Director
Division of Systems & Monitoring
Health and Recovery Services Administration
Washington State Department of Social and Health Services

STATE OF COLORADO

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Bill Owens
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Stephen C. Tool
Executive Director

July 24, 2006

Rec'd
JUL 25 2006

Melissa Musotto
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulatory Development
Room C4-26-05, 7500
Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Musotto:

Attached, please find the Colorado Department of Health Care Policy and Financing's response to the Eligibility Error Rate Measurement Supporting Statement issued on May 26, 2006. We appreciate the opportunity to comment.

If you have any questions, please do not hesitate to contact me at (303) 866-3676 or by e-mail at donna.kellow@state.co.us.

Sincerely,

Donna Kellow
Audit Coordinator

cc: Lisa Esgar

Comments to the Proposed Rule and Supporting Statement to the Eligibility Error Rate Measurement in Medicaid and the State Children's Health Insurance Program

Department of Health Care Policy and Financing
July 24, 2006

The Colorado Department of Health Care Policy and Financing seeks clarification on several items within the Supporting Statement published by the Centers for Medicaid and Medicare Services (CMS) on May 26, 2006.

Overall Questions

- It is not clear from the Supporting Statement when the eligibility reviews will begin. As with many other states, there are legislative and budgeting schedules that make it difficult for states to receive funding and be prepared to implement this project without a sufficient implementation period. If the regulation will be effective immediately and start with year two states, Colorado will be faced with a difficult and burdensome process that could result in less accurate findings. Please consider deferring implementation until FFY 2008. Please clarify the effective date of this regulation.

- The Supporting Statement makes no mention of loss of FFP or penalties for error rates above 5%. Will there be any penalties? If there will be penalties, what will the procedure for disallowances or penalties be?

- CMS should produce a timeline and a state schedule for the Medicaid and SCHIP reviews so it would enable states to be more prepared and for the process to go smoother. Likewise, the earlier the information is sent to the states, the more efficient the process can be.

- 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?

- There are no provisions for the states reviewing the federal contractor's findings regarding the SCHIP cases. If states are not provided this opportunity, the error rate may not be accurate due to misinterpretation on the part of their federal contractor. There should be a provision that supports a state review function and a timeline that allows the state the ability to fully review any findings.

Page one of the Supporting Statement, third paragraph, first bullet

The bullet states that "we determine the states shall: Review eligibility in the same year the states are selected for Medicaid and SCHIP FFS and managed Care reviews". It is not clarified anywhere else in the Supporting Statement whether or not the state would be

expected to do both Medicaid and SCHIP reviews in the same year. Doing both reviews in one year would be burdensome to the state and difficult to manage resources. Colorado respectfully asks that CMS does not impose such a requirement.

Page two of the Supporting Statement, first bullet

Please clarify the manner in which states will be required to calculate the elgibility error rate.

Page two of the Supporting Statement, second paragraph

The Supporting documents state that there will be a standardized review methodology. Will the states be able to comment on the proposed methodology? Will there be flexibility with the review methodology?

Page three of the Supporting Statement, second paragraph

Please define what constitutes "undetermined".

Page five of the Supporting Statement, Sample Size Development.

Please clarify how unobtainable information will factored into the error rate. This includes information not received from the client or eligibility worker.

Page seven, Case Reviews

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.

Minnesota Department of **Human Services**

July 24, 2006

Rec'd
JUL 25

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development—A
Attention: Melissa Musotto, Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244--1850

Re: CMS-10184 (Federal Register 71 FR 30409, May 26, 2006)

To Whom It May Concern:

Thank you for this opportunity to comment on CMS's information collection proposal pertaining to Payment Error Rate Measurement of Eligibility in Medicaid and the State Children's Health Insurance Program (SCHIP).

Be assured that Minnesota considers eligibility and payment accuracy a very high priority. Consequently, we appreciate all opportunities to help refine PERM methodology. All of our questions, comments and recommendations have been shared with APHSA, the American Public Human Services Association, and are reflected in the letter that is being submitted to CMS by their Executive Director. The issues discussed in the paragraphs below are those that we consider especially important to Minnesota.

- In the Supporting Statement, CMS indicates that the PERM Medicaid eligibility measurement will be "case-based." Minnesota is one of several states that determine the eligibility of the individual first and the eligibility of the case second, specifically with respect to Medicaid family cases. Consequently, it may be more appropriate for such a state to select an "enrollee-based" sample rather than a "case-based" sample. Since the eligibility of each individual enrollee is determined independently of each of the other family members, sample selection by case would produce less valid results than sample selection by enrollee. In addition, it would substantially increase the workload for the staff responsible for conducting recipient eligibility reviews. Will states such as Minnesota be allowed to select Medicaid samples using enrollees as the sampling unit rather than cases? If so, please provide states additional information regarding how the formula for computing the eligibility review error rate will be adjusted to accommodate this modified approach.

- Minnesota is currently fulfilling its MEQC obligation within the guidelines of the Pilot Project and prefers to continue in this status. For that reason, we request confirmation of our interpretation of the paragraphs on page 3 of the Supporting Statement which indicate to us that states conducting pilots under MEQC can temporarily replace the pilot responsibilities with PERM or traditional MEQC responsibilities during the year that they are randomly selected for participation in PERM. Are we correct? And, equally important, will states be allowed to return to pilot status when their year of PERM reviews is over?

- Like other states, Minnesota appreciated the verbal assurances from Kim Brandt and Janet Reichert during the July 18th conference call that PERM does not contain any new authority to recoup Medicaid dollars from states when payment errors are discovered. As we understood the comments, any repayment will be based on the specific payment errors identified by the PERM review and not on any error statistic extrapolated from the state's PERM sample of claims/cases and generalized to the Medicaid universe of payments. We strongly recommend that CMS include this assurance in the paragraphs of the forthcoming Interim Final Rule to be published in August, 2006. We also recommend that the Interim Final Rule reiterate their comment that PERM will focus on generating a national error rate and not attempt to compare the performance of states using state-specific error statistics.

- Please clarify the sampling parameters states are expected to use to select the monthly samples of the three unique strata of active cases/recipients for the PERM eligibility reviews: (a) confidence interval, (b) confidence level, and (c) 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.

- Page 2 of the Supporting Statement says: "States will select monthly samples and conduct the reviews using a CMS standardized review methodology". However, the components of that "standardized review methodology" are not described anywhere in the document. We request that CMS provide Minnesota and all states with additional information specifying in detail the methodology that states are expected to use to complete a review of case/recipient eligibility for PERM.

Again, thank you for this opportunity to comment on the proposed PERM information collection methodology pertaining to recipient eligibility reviews.

Sincerely,

Christine Bronson

Christine Bronson
Medicaid Director

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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July 18, 2006

Rec'd
JUL 25 2006

Melissa Musotto
Center for Medicare and Medicaid Services
Office of Strategic Operations & Regulatory Affairs
Division of Regulations Development - A
7500 Security Boulevard, Room C4-26-05
Baltimore, MD 21244-1850

Dear Ms. Musotto:

The Wisconsin Department of Health and Family Services respectfully submits the following comments about the supporting statement for Eligibility Error Rate Measurement in Medicaid and the State Children's Health Insurance Program. The supporting statement was published by the Centers for Medicare and Medicaid Services (CMS) and attached to the May 26, 2006, Federal Register Notice.

Undetermined Cases
Section B, item 4, Duplication of Efforts: This item indicates that states will be able to cite cases where eligibility cannot be determined as "undetermined." This seems to be contradictory to section B item two where it states, "to ensure the states complete reviews on **all** cases sampled."

Verification
Section B, item 4, Duplication of Efforts: This item states CMS has worked to make active case review requirements less stringent by minimizing the verification requirements, but specific information about verification requirements was not provided. In order to fully assess the impact of the eligibility review requirements, additional information about the proposed verification requirements is needed.

Case Reviews
It is stated in the case reviews section that there will be 34 states needed annually to produce a national eligibility error rate: 17 for Medicaid and 17 for SCHIP. It is unclear whether each state will be required to conduct both Medicaid and SCHIP eligibility reviews within the same year, or whether states will be selected for Medicaid and SCHIP eligibility reviews in two years within each three-year period. The first paragraph of Section A states "the Federal contractor will review states on a rational basis so that each state will only be measured for improper payments, in each program, once and only once every three years." In order to assess workload and staffing needs, states need to know if both Medicaid and SCHIP eligibility reviews could be required within the same year.

Eligibility Review Process Details

State Policy
It is stated in the Case Review section that "(s)tates will conduct reviews in accordance with the state's eligibility policies that are in effect as of the review month" and "there is no administrative period." This seems contradictory, because advance notice requirements are required by Federal policy as outlined in 42 CFR 431.211, and are thus incorporated into State eligibility policy.

Relationship between SCHIP and Medicaid Eligibility
Although this concern was not specifically addressed in the supporting statement, we would like to reiterate our position that SCHIP recipients who are determined ineligible for SCHIP but would qualify for a Medicaid subprogram should not be considered totally ineligible. In Wisconsin, full benefit Medicaid and SCHIP recipients are eligible for exactly the same benefit package. 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 truly ineligible for health care coverage. We therefore contend that the true error amount in this example is only the difference in rate of federal financial participation, not the entire SCHIP claim.

Error Rate Calculation
The supporting statement lacks specific information about the formula for calculating each state's payment error rate. We have the following questions and comments:

- 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.
- There is significant variance in states' caseload sizes, yet it has been proposed that all states will be required to conduct the same number of reviews. Will states be given the option to conduct more than 501 active and 200 negative cases per year per program?
- For cases where the accuracy of the eligibility determination is considered "undetermined," are the payment amounts included in the error rate denominator?
- 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?

Burden Estimate
In the burden estimate section, there is mention of "possible interviews." If there will be any requirement to conduct client interviews, we believe the estimates of 10 to 15 hours per eligibility review are unrealistic.

In closing, we would like to thank you for the opportunity to comment on this important proposal, and for your efforts to obtain comments from state agencies and other interested parties, as Wisconsin remains committed in our effort to achieve payment accuracy. Please do not hesitate to contact us if you have questions regarding our comments, or if we can provide additional information.

Sincerely,

Cheryl McIlquham
Interim Administrator

CM:dd
BE07030

cc: Jim Jones, DHCF/BEM
Alan White, DHCF/BHCPI
Vicki Jessup, DHCF/BEM

APHSA
American Public Human Services Association

July 25, 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

Rec'd
JUL 25 2006

Attention: **CMS–10184**

Re: Agency Information Collection Activities: Proposed Collection — Payment Error Rate Measurement of Eligibility in Medicaid and the State Children's Health Insurance Program (SCHIP)

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 agency information collection notice published in the May 26, 2006, *Federal Register* (71 *FR* 30409) for the Centers for Medicare and Medicaid Services (CMS).

We appreciate that CMS addressed in its May 26, 2006, notice a number of the issues we raised in 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. We also are encouraged that CMS has taken a first step to seek consultation from states as it further develops the PERM requirements. Still, there are a number of issues for which states need clarification and wish to offer recommendations.

As discussed in our comments below, APHSA believes that CMS should facilitate a more comprehensive dialogue by providing additional details on PERM prior to moving forward with implementation in other states. Further, there are a number of confusing issues and areas where states simply lack sufficient information to fully evaluate CMS' PERM plans. Specifically, states have received minimal information with regard to implementation of the eligibility component of PERM, development of the samples, and review of the cases. In turn, without such information, we believe CMS has underestimated the burden to states to comply with PERM. 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 will permit the substitution of the federal Medicaid Eligibility Quality Control (MEQC) program for PERM reviews, the methodology and transition issues essential for states to assess the value of this option were absent from CMS' latest notice. One useful step that CMS can take to assist states in this process and ensure consistency across states is to develop a matrix or chart explaining the options and requirements associated with each component. A matrix or chart also would assist states in understanding the various components and requirements of the basic PERM requirements, including the SCHIP and eligibility components.

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:

- Clarification on the eligibility component of PERM reviews;
- Methodology issues related to review of active and negative cases;
- Methodology and implementation issues related to the substitution of MEQC for PERM;
- Transition and implementation issues related to "pilot states";
- Intersection of PERM and other programs that have a fraud and abuse component, including the new Medicaid Integrity Program (MIP);
- Definitions of the program integrity requirements as they relate to the SCHIP program; and
- Increased transparency and collaboration in the development of PERM.

A. Background

- CMS stated that it convened an eligibility workgroup to obtain recommendations for measuring Medicaid and SCHIP improper payments based on eligibility errors. We appreciate that CMS took advantage of the expertise of states and we were pleased to read in the Supporting Statement that the agency accepted many of their recommendations. In the spirit of transparency APHSA requests that CMS make these recommendations public and, where appropriate, provide an explanation for its decisions in relation to these recommendations.

  APHSA wishes to reiterate its strong opposition to any attempts by CMS or other federal agencies to utilize the national payment error rates to impose negative fiscal penalties on states. We understand that the PERM program necessarily will result in "reviews." APHSA requests that CMS specify whether such reviews will include "findings." If so, we further request that CMS indicate how it will utilize these findings and what agencies, organizations, individuals or other entities will have access to such information.

As noted in the Supporting Statement and previous regulatory documents, the Improper Payments Information Act of 2002 requires that CMS produce a national error rate. This statute in no way confers authority to the federal agencies to determine and utilize a state-specific error rate for the purpose of imposing fiscal penalties on individual states. APHSA urges CMS to clarify this policy in its future guidance.

- The Supporting Statement indicates that states selected for review must submit an initial eligibility sampling plan to CMS for approval 60 days prior to the fiscal year being reviewed. APHSA urges CMS to provide significant time for states to respond to and amend their sampling plan, as needed.

- APHSA requests clarification of language in the Supporting Statement that references CMS' process and timelines for notifying states when the managed care, SCHIP, and eligibility components would be included in the PERM review process. In addition, if all three components of PERM (SCHIP, Medicaid and eligibility) are done in a state in the same year, APHSA recommends that states not be required to develop a separate sample for eligibility reviews?

  It is our understanding that under PERM, if the medical or processing review revealed an error, then the eligibility portion did not need to be reviewed for this case since an error was already discovered. As such, we ask that CMS provide clarification for when the eligibility reviews must be completed since there will be a lag time between the medical/processing review completion.

- APHSA recommends that CMS waive SCHIP's provision that imposes a 10 percent cap on administrative expenses during the year when a state does its SCHIP PERM review. States will need to invest significant resources in administrative costs in the year they are subject to the SCHIP PERM review, and this cap is likely to impede their ability to fully comply with PERM and/or SCHIP regulations.

- In addition, APHSA requests 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.

- In the Background section, CMS explains the sampling parameters states will use. However, states believe this section conflicts with the text on the same subject in section C, "Collections of Information Employing Statistical Methods." The former indicates a 95 percent confidence interval, using the mid-point of the confidence level, with +/-3 percent precision. The latter indicates a 95 percent confidence level, using the mid-point of the confidence interval, within 3 percent precision. The words "interval" and "level" are used differently on each, prompting the need for clarification. In addition, in section C, CMS indicates that, to estimate the average

state sample size, CMS assumed an error rate of 5 percent. Since CMS does not indicate that the states should also assume an error rate of 5 percent when choosing their samples, APHSA 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.

- The Supporting Statement reads that, "Using a standard formula, states will then calculate and report to CMS, state-specific eligibility error rates based on the review results." States request clarification as to the frequency of this reporting of this error rate.

  APHSA also requests that CMS clarify the formula states will be required to use to calculate the state-specific eligibility error rate based on the review results. In addition, we request further clarification for the formula that will be used to calculate the state-specific payment error rate that is uniquely attributable to eligibility errors.

- The Supporting Statement reads that, "States will select monthly samples and conduct the reviews using a CMS standardized review methodology." States are concerned with the unspecified CMS standardized review methodology. APHSA is aware that recommendations were made by the Eligibility Workgroup and that these are not reflected in the current information released by CMS. APHSA believes it is appropriate for CMS to re-engage states and other stakeholders in reviewing and revising the methodology. In addition, we ask that CMS provide a timeline for when this methodology is expected to be available.

- During the PERM Pilot project, states used specific definitions/categories of "recipient error." APHSA asks that CMS clarify whether these same definitions/categories will be employed in the PERM program going forward.

B. Justification

3. Use of Information Technology

- APHSA is pleased that CMS intends to allow states to electronically submit information provided that they have the technological capability and secure systems in place. To proceed with electronic submissions, states will need additional information explaining how this will be accomplished. For example, the Food and Nutrition Service (FNS) and Administration for Children and Families (ACF) provide the software and connectivity to their web sites for data edit checks, transmission, and confirmation of data received for the Food Stamp and Transitional Employment Assistance (TEA) programs. APHSA encourages CMS to follow these model practices, which will in turn help to streamline the work for states and CMS' PERM contractors.

4. Duplication of Efforts

- APHSA applauds CMS' decision to mitigate any duplication of effort for those states performing traditional Medicaid Eligibility Quality Control (MEQC) reviews and to reduce cost and burden for all states conducting pilots under MEQC. Specifically states are permitted, pending CMS approval, the option of using the MEQC traditional reviews to meet the PERM eligibility requirements for Medicaid. To assist states in understanding the available options, APHSA requests that CMS develop a schematic and/or matrix that compares and contrasts the criteria needed under "traditional" and "pilot" MEQC reviews and PERM review criteria. We strongly believe this will help to minimize confusion about requirements under each option and clarify for states any risks associated with each. The supporting statement issued with the May 26, 2006, notice also indicates SCHIP "program integrity requirements" as potentially meeting PERM review criteria. To this end, we urge CMS to include SCHIP criteria in any such schematic or matrix.

- The option to use MEQC reviews is appealing to states currently using the traditional method and those in "pilot" MEQC projects so that they can minimize any duplication of effort. APHSA strongly recommends that CMS ensure that states have the flexibility to use the traditional MEQC method in the year they are selected for PERM review and the ability to revert to "pilot" MEQC methods in non-PERM review years, at state option. To streamline this process and facilitate successful, accurate substitution of the programs, APHSA recommends that CMS provide states with guidelines for the steps entailed in the conversion from traditional to pilot MEQC methods. In addition, we recommend that states retain this substitution option in years when states are chosen for SCHIP eligibility reviews.

- APHSA also supports recommendations made by states in the CMS Eligibility Workgroup for implementing the MEQC–PERM "substitution." Specifically, in states choosing to substitute the MEQC review for the PERM eligibility review, we encourage CMS to accept the state's most recently reported MEQC error rate as meeting MEQC requirements while the state's MEQC staff performed PERM eligibility review duties. APHSA is concerned that without this consideration, states' resources would be further strained by the concurrent requirements of performing PERM and MEQC reviews.

  The discussion in the Supporting Statement seems to imply that a state's use of the PERM sampling plan to perform MEQC reviews satisfies both PERM and MEQC reporting requirements. However, PERM review requirements are fundamentally different from MEQC or, when applicable, SCHIP quality control requirements. APHSA is concerned that the rates derived from such a combination may satisfy PERM requirements but would be inherently flawed for MEQC reporting.

- APHSA requests clarification on the scope of "CMS approval" of a state's PERM sample plan (Medicaid or SCHIP). Specifically, APHSA would support the

implication in the Supporting Statement that such approval of a state's sample plan means that the agency also approves a state's eligibility review methodology.

- APHSA understands that states can opt to conduct traditional MEQC "positive" reviews in place of PERM. We request clarification as to whether this substitution option also will be permitted for "negative" reviews only. That is, regardless of how a state chooses to handle "active" cases, we seek further guidance on whether a state can use the traditional MEQC method for "negative reviews" in place of PERM negative reviews. For the active and negative cases, CMS could assist states by providing eligibility review flowcharts. Such a flowchart would support consistency among the states.

- APHSA appreciates CMS' efforts to "make the active case review requirements less stringent than required under the MEQC program." However, additional information about the proposed verification requirements is essential in order for states to fully assess the impact of the eligibility review requirements. States also request additional information on the differences and steps CMS has taken. Specifically, we are interested in how verification requirements have been minimized and what case exclusions from the universe are allowed.

12. Burden Estimate

- APHSA appreciates that CMS has continued to revise its estimate of the hours required to respond to requests, now 13,180 per state, and the cost per state per program, now $532,340. However, we continue to believe that these estimates do not reflect the entirety of the burden imposed upon states. Most states have indicated that it is unlikely that they can initiate and support the eligibility effort for $532,340. To support the PERM eligibility initiative, it appears that states will need to hire and train additional staff.

  Specifically, we urge CMS to further revise its estimates to reflect the staffing and training needs, eligibility processing methodology/complexity, size of travel area/transportation mode, case record accessibility, and the range of other factors that challenge reviewer proficiency.

  In addition, states believe it is arbitrary and inadequate to calculate total cost (per state, per program) using a GS-12 salary as the base and the CMS fringe and overhead rates. The three figures – salary, fringe, and overhead – will vary widely from state to state. APHSA recommends that CMS develop a range for the burden estimate. One of the larger states reported that just to hire and train seven reviewers to complete eligibility reviews would cost over $640,000.

- As discussed in our November 5, 2005, comments, budget requests for state staff must be submitted far in advance, particularly in those states with two-year

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

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

- APHSA requests clarification on the required review activities of the eligibility review itself. The Supporting Statement references the Medicaid eligibility review requirements in 42 CFR 431, subpart P, which appear to require an in-person recipient interview to accurately determine eligibility. States have reported that it would save significant time and staff resources if the in-person interview requirement was made only when accurate determination of eligibility necessitated such an interview. Pursuit to this, states recommend that the in-person recipient interview be required only when correctness of agency action cannot be determined by review of the case record. Should CMS require states to conduct client interviews, states believe the estimates of 10 to 15 hours per eligibility review are inadequate. As such, APHSA requests that CMS revise the PERM burden estimates to reflect time and resources for conducting interviews.

- CMS also should take steps to inform states of the reimbursement for staff time and other expenses to comply with the PERM regulations. APHSA believes it is appropriate that CMS provide 100 percent reimbursement to states that conduct the PERM review as well as for those that choose to substitute MEQC for PERM reviews.

- As we suggested in our August 15 comments and reiterated in our September 26 comments on the proposed information collection initiative, a solution to the difficulty in estimating states' burdens is for CMS to provide 100 percent reimbursement for staff time and other expenses to comply with CMS' PERM regulations. It seems likely that the first PERM round will be the most onerous, where states essentially are transferring a large body of medical review, systems, and provider information knowledge to PERM contractors. We encourage CMS to consider additional support to states during this startup phase to ensure that the process is workable and that both states and CMS are satisfied that the resulting error rates are valid, consistent, fair, and accurate. Neither CMS nor states will be well served by PERM results that are based on incomplete data, a flawed methodology, or inconsistent application. CMS could avoid considerable criticism by ensuring that states have the resources to adequately support the PERM contractors during the all-important first round.

12.4 Corrective Action Plans

- As we noted in our November 5, 2006, comments, we encourage CMS to enter into a dialogue with states to identify the components of model corrective action plans so that these can be refined and agreed upon before the PERM information collection process begins. We suggest that CMS establish a steering committee or other advisory group that includes state representatives to help ensure that the PERM contractors consider all the logistical issues and address potential data collection issues before beginning their onsite and interactive work with states in collecting medical review policies, manuals, and system documentation. For states with fiscal agents, obtaining systems documentation is likely to require assistance from fiscal agent staff, which may involve contracting changes or unanticipated additional support expenses. If state representatives have the opportunity to participate through an advisory or other steering committee, states might be able to assist in reducing the "steep learning curve" facing federal PERM contractors and reduce demands on state staff to support the PERM contractors.

Sample Size Development

- APHSA is concerned with CMS' decision to choose the same number of cases for review by each state regardless of the size and capacity of the state. Specifically, APHSA believes it is unreasonable to require states to review 701 cases for eligibility, regardless of the size of the state caseload. We request that CMS provide further explanation for this decision and reconsider this approach and/or revise its burden estimate to reflect the disproportionate burden this will have on states, depending on state caseload and other appropriate factors.

- In the Supporting Statement CMS indicates that the measurement will be "case-based." CMS should be aware that there are several states that determine the eligibility of the individual first and the eligibility of the case second, specifically with respect to Medicaid family cases. Consequently, it may be more appropriate for such a state to select an "enrollee-based" sample rather than a "case-based" sample. Since the eligibility of each individual enrollee is determined independently of each of the other family members, sample selection by case would produce less valid results than sample selection by enrollee. In addition, it would substantially increase the workload for the staff responsible for conducting recipient eligibility reviews. APHSA requests that CMS clarify if such states will be allowed to draw Medicaid samples using enrollees as the sampling unit rather than cases. In addition, if so, states will need additional information regarding how the formula for computing the eligibility review error rate will have to be adjusted to accommodate this modified approach.

- It remains unclear in the Supporting Statement the method states should employ for the active and negative reviews and for calculating the state-specific error rate. APHSA encourages CMS to make available resources and technical assistance for states to comply with these requirements. In addition, we recommend CMS issue further details explaining how the federal contractor will calculate the national error rate for Medicaid and SCHIP.

- APHSA also requests clarification on how states should handle cases that are not subject to review or cannot be completed due to non-cooperation of recipient or collateral contact. In addition, we ask that CMS explain how these cases will be handled in determining a state's error rate.

Case Reviews

- APHSA was pleased to note that CMS added an additional 2,135 hours to the 7,845 case review hours CMS estimated for supporting functions like training, supervision, quality assurance, and creation of review tools. However, at least one state estimated that adequate training of eligibility case reviewers alone would be in excess of 1,000 hours, thus leaving only about 1,000 hours for supervision, coordination, re-reviews, creation of review tools, tracking programs, and quality assurance. APHSA strongly recommends that CMS further revise upwards its estimate of case review hours since the current 1,000 hours is not likely to be sufficient to accomplish these supporting functions for states.

- APHSA understands that CMS will soon incorporate the eligibility component in the PERM review process. APHSA requests several clarifications related to the timing of its inclusion. First, in the Supporting Statement, CMS indicates that states shall "Review eligibility in the same year that the states are selected for Medicaid or SCHIP FFS and managed care reviews." The use of the word "or" indicates that states will be selected to conduct full PERM reviews (claims processing, medical, and recipient eligibility) for either Medicaid or SCHIP claims/cases, but not both, every third year. APHSA believes this is consistent with CMS' statement on page 4, paragraph 6, which states, "Each year, 17 states will participate in the Medicaid error rate measurement project and 17 states in the SCHIP error rate measurement project." However, this appears to conflict with the statement in the text of the May 26 announcement, which reads "...each state will be measured for improper payments, in each program, once and only once every three years." Specifically:
    - Once a state completes the first PERM eligibility review, will it then get a respite of two years before it is required to do eligibility reviews for the program it did not review the last time (be it SCHIP or non-SCHIP/Medicaid), assuming that SCHIP and Medicaid are sampled separately?

- Instead, if all three components of PERM are done in a state in the same year, will the "eligibility" review component be independent of the reviews for the other two components? That is, will a separate sample need to be drawn for it even if all three components are being done at the same time?

It is imperative that states have clear guidance as to how implementation of the eligibility component will impact states that already have been selected for the PERM review in the first phase, prior to the eligibility component. As such, APHSA requests that CMS issue clarification so states may determine the process for selection for PERM review.

Further, states already face a number of new burdens associated with the implementation of PERM reviews, including additional staffing and funding resources. APHSA recommends that CMS not subject a single state to PERM reviews of both its SCHIP and Medicaid program in the same year.

- The CMS Supporting Statement indicates the active cases are divided into three strata: stratum 1 is completed applications for the sample month, stratum 2 is completed redeterminations for the sample month, and stratum 3 is all other active cases. In some states, the redetermination is often completed in one month with an effective date for the following month.

  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.
  - That is, should applications that are opened as administrative applications, such as reopenings following an appeal reversal, be excluded from the universe for stratum 1?
  - Would these applications meet the definition of a completed application 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?

- APHSA requests that CMS provide states the flexibility to utilize case review documents and other primary and secondary collateral sources for active case reviews. Many states already have efficient processes in place to determine cost and error rate for eligibility reviews. For example, at least one state has an internal case review accuracy rate of 98 percent when determining eligibility.

- In the Supporting Statement, CMS indicates that "states can cite cases where eligibility cannot be determined as 'undetermined.'" States often experience difficulty when conducting recipient eligibility audits on negative action cases

(e.g., denials and terminations) due to the unwillingness of the sampled cases to provide requested information and data. States report that the problem is exacerbated by the fact that the state has no legal authority to mandate cooperation. As such, APHSA requests that CMS provide adequate flexibility for dealing with these cases, clarify at what point a review would be shown as "undetermined" in the review process, and indicate the type of documentation that CMS will require to demonstrate this. Further, states are concerned that the statement in Section B, item 4 contradicts Section B, item 2 which states, "to ensure the states complete reviews on all cases sampled."

- CMS assumed that the payment error rate would be determined by using payments for services received in the first 30 days of eligibility for new cases or newly recertified cases (strata 1 and 2) and in the review month for ongoing cases (stratum 3). However, Medicaid and SCHIP providers have up to 12 months to submit a bill for payment, and not all providers bill Medicaid immediately. APHSA requests that CMS provide states with additional guidance indicating the length of time that they are permitted to obtain this information. In addition, CMS should provide guidance to states as to how they should treat cases with no paid claims for the particular month. That is, we ask that you address whether a payment error rate will be determined only on bills paid as of the review date.

- The Supporting Statement directs states to attach payments for services received for recipients in each of the sample strata. APHSA requests clarification of this statement, including further information on what the cost recovery will be.

  States understand that they are still required to comply with the current Title XIX recovery requirements. However, pursuant to this section of the Supporting Statement, APHSA is concerned that CMS and/or other federal agencies intend to use the PERM program as a cost recovery project even though this is not the purpose of the initiative. Specifically, we are concerned that the Supporting Statement directs states to reimburse the Medicaid program for eligibility errors. If one or all components of the PERM program were employed for cost recovery purposes, APHSA would request that CMS explicitly state this function and provide stakeholders with another opportunity to review the guidance in this light.

- The Supporting Statement indicates that CMS will permit states to exclude active fraud investigation cases from the sample. APHSA encourages CMS to exclude other types of cases since they would pose similar challenges in conducting the PERM review, including cases in fair hearing status and cases where the sampled person is discovered to have SSI eligibility under a different program number. APHSA notes that this is a common practice in 1634 states, where SSI recipients are auto-enrolled into Medicaid. Further, APHSA encourages CMS to exclude cases that are being actively investigated for possible fraud in the Food Stamp Program, the TANF program, the SSI program, and others.

- APHSA disagrees with CMS' decision to exclude an administrative period that is contrary to the procedure in MEQC (see 42 CFR 431.804). For strata 1 and 2, the review is focused on the completed applications and redeterminations in the review month. The PERM review would determine if the completed application or completed redetermination action was correct at the time the action was taken in the sample period; however, the other active cases could have actions in prior months as far back as 12 months. Examples could include the time during which a case may have aid continuing pending a fair hearing on a negative decision, or the period between the decision and the tolling of a federally required timely eligibility notice to the client. It is currently unclear how payments during such periods will be treated. APHSA supports efforts to ensure that the continuing provision of services pending the outcome of a hearing or the clockdown of a case closing would not count against the state, if the eligibility decision was correct.

  In addition, under certain circumstances, MEQC presently allows an administrative period for changes that take place in the review month or the month prior. This period allows the caseworker time to react to the change and provide timely notice without being cited in error. States support inclusion of the administrative period, specifically for stratum 3 cases, to ensure that the review reflects changes in clients' circumstances when reported in the month prior to the review month.

  CMS also states in this section that "States will conduct reviews in accordance with the state's eligibility policies that are in effect as of the review month" and "there is no administrative period." States request that CMS clarify any contradictions that may occur between these statements and advance notice requirements as required by federal policy (42 CFR 431.211), and are thus incorporated into state eligibility policy.

- APHSA appreciates CMS' efforts to coordinate the Medicaid and SCHIP PERM requirements. However, we remain concerned with a number of inconsistencies or lack of information in the notice that is critical to states meeting the PERM requirements. The Medicaid and SCHIP program do not always have corresponding "program integrity requirements." As such, we ask CMS to further clarify the guidelines that states may use to ensure their SCHIP programs can be appropriately substituted for PERM.

- The different SCHIP program structures raise other questions for PERM implementation. We ask that CMS consider how it treats SCHIP recipients who are determined ineligible for SCHIP but would qualify for a Medicaid program and ask that you not consider them totally ineligible. For example, in one state full-benefit Medicaid and SCHIP recipients are eligible for exactly the same services. 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 truly

ineligible for health care coverage. In this example, a preferable interpretation for purposes of PERM may be to define the true error amount as only the difference in rate of federal financial participation, not the entire SCHIP claim.

- APHSA recommends that payment error rates include a payment error tolerance threshold. During the PERM pilot in at least one state, the SSA BENDEX Report was off by $1 to $2 after each annual COLA. This resulted in spend-down errors of $6-$12 each six-month spend-down period. States should be able to rely on the BENDEX for verification of SSA income. Because of the continued discrepancies with the report, PERM eligibility reviews should allow for at least a $12 payment error tolerance threshold. APHSA wishes to note that, in comparison, USDA allows a $25 payment error tolerance threshold.

- We wish to reiterate from our November 5, 2005, comments that providers historically are very guarded about the confidentiality of their files, and can be expected to provide a challenging environment to contractors requesting records. Many state programs routinely request records multiple times and still must resort to creative tactics, such as having fiscal intermediaries assist in getting complete records. APHSA encourages CMS to implement incentives in PERM contractors' statements of work to ensure these contractors have thorough data collection protocols for identifying providers and obtaining complete documentation. States are concerned that if CMS' contractors are less persistent than states in obtaining provider records, contractors could unintentionally inflate states' PERM rates. Experience from states participating in the PAM Pilots has shown that obtaining adequate documentation can be the most labor-intensive part of claims audits. Thus, APHSA suggests that CMS collaborate with states to develop model letters, other processes, and guidance to ensure provider cooperation. States also verify medical necessity determinations with physicians and we encourage CMS to include this step in the contractor workplans, even though this might prove difficult in rural states where providers can be unavailable in some areas.

Collections of Information Employing Statistical Methods

- States remain concerned that there is no specific provision for states to re-review audit findings or rebut initial error determinations. In some situations, states may be able to explain apparent errors by reviewing the case or expending additional effort in obtaining or interpreting provider documentation. Some errors could arise from the need for insight in interpreting states' medical policies, and these interpretation cases could easily be resolved through a process where states are formally permitted to review all errors using the documentation collected and used by the contractor before final error rates are established. We encourage CMS to explicitly develop a formal process for states to re-review all errors before final error rates are established. In addition, we also encourage CMS to create provisions for providers to appeal medical findings portion or, alternatively, to

create a mechanism by which providers could challenge medical error payment recovery.

Miscellaneous

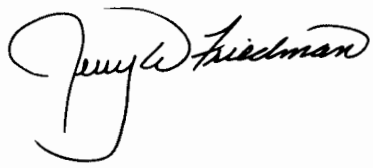
- As noted in our previous comments, we believe that the PERM program can be improved through increased transparency, including through process clarifications around deadlines and expectations for states. For example, we have heard from a number of states that do not have clear guidance on which contractor will be contacting them and when they should expect such contact. APHSA recommends that CMS develop some form of "PERM project plan" that can guides states in audit steps, responsibilities, timelines, and completion expectations. Such a resource would improve efficiency and effectiveness of CMS's PERM program and would minimize confusion among states, thereby helping to reduce questions and ongoing technical assistance needs from states.

- Related to the previous bullet, APHSA is concerned with reports from a number of states that are struggling with the burden of anticipating the PERM process and deadlines in the short term. As such, APHSA encourages CMS to make available as soon as possible anticipated schedules for fiscal year 2007 and each subsequent year in a timely fashion. Advance notice of the PERM schedule deadlines is critical to states' planning, including their organizational and budgetary processes.

- Several new projects and initiatives are now underway at the federal and state levels. As with the MEQC program, although distinct, many of these initiatives have overlapping goals and functional steps for implementation. Specifically, the new MIP is likely to have some overlap with PERM. APHSA encourages the CMS division administering PERM to collaborate with its counterparts who are developing and implementing the MIP to minimize any duplication of efforts and clarify how the programs may overlap and/or interact. APHSA asks that CMS indicate whether the PERM review results will be provided to the new MIP and how such findings might be used.

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,



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July 25, 2006

Dr. Mark B. McClellan
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6026-P
P.O. Box 8017
Baltimore, Maryland 21244-8017

Rec'd
JUL 25 2006

Attention: CMS-10184

Re: Agency Information Collection Activities: Proposed Collection – Payment Error Rate Measurement of Eligibility in Medicaid and the State Children's Health Insurance Program (SCHIP)

Dear Dr. McClellan:

The Illinois Department of Healthcare and Family Services, which administers Medicaid and the State Children's Health Insurance Program (SCHIP) in Illinois, has reviewed the draft PERM eligibility review regulations and offers these comments.

As the first state to conduct a Medicaid payment accuracy review, we understand both the value of a well-designed measurement program and the significant effort and cost such measurement efforts require. However, we believe the PERM eligibility review regulations proposed by the Centers for Medicare and Medicaid Services (CMS) represent a significant lost opportunity to provide Congress and the public with the best estimate of Medicaid improper payments and address states' concerns about burden.

CMS, the states, and its contractors have devoted significant effort to the development and implementation of the PERM claims sampling methodology, and it is unclear why CMS does not want states to review the eligibility of beneficiaries whose services are selected for review in the PERM claims sample (See first dot point under Background below). That approach would provide CMS with the best possible estimate of improper payments, while allowing CMS and states to understand the relative importance of fraud, billing errors, or eligibility errors in determining the overall improper payment rate. This information-rich and integrated approach is on a far stronger statistical foundation than the approach currently proposed, and depending on how it is implemented, would likely be far less burdensome and costly to implement for both states and CMS.

In implementing this integrated review, it is imperative that CMS work with the other areas within the U.S. Department of Health and Human Services to ensure that the PERM eligibility review will be approved as a pilot under the current MEQC requirements. Illinois and other states simply do not have the resources to do both.

Below are our other comments on each section of the supporting statement:

A. Background

In regards to the requirements and the purpose of the eligibility reviews required under the Improper Payments Information Act of 2002, we propose the following:

- In order to reduce the burden on states related to the PERM eligibility and provide CMS and its stakeholders with the most accurate information possible, we strongly encourage CMS to consider integrating the PERM eligibility review with the claims review. This would enable CMS to provide a complete and unified estimate of the dollars lost to fraud, abuse, billing, and eligibility errors, along with service and eligibility determination errors. At the same time, since the Lewin Group is already selecting the claims sample this change would eliminate the need for states to submit an eligibility sampling plan, selecting monthly eligibility samples, submitting monthly sample lists, attaching payment reviews and conducting negative reviews.

  By conducting an eligibility review of the beneficiary for that date of service on the claim already selected for review, the burden on states would be significantly reduced while the quality and accuracy of the information obtained would be significantly improved. To gain the full impact of burden reduction and meet MEQC reporting requirements we would also propose that these eligibility reviews (either for Medicaid or SCHIP) be accepted by CMS as MEQC Pilot reviews for a state's PERM years.

- Illinois recommends that CMS not subject a single state to PERM reviews of both its SCHIP and Medicaid program in the same year. States already face a number of new burdens associated with the implementation of PERM reviews. These include identifying funds for these unfunded mandates, diverting, hiring, and training additional staff, and devoting management resources to the planning and logistical aspects of these reviews.

B. Justification

- Illinois is concerned that CMS or other federal agencies will attempt to utilize the national payment error rates to impose a negative fiscal penalty on states. As noted in the Supporting Statement and previous regulatory documents, the Improper Payments Information Act of 2002 requires that CMS produce a national error rate. This statute in no way confers authority to the federal agencies to determine and utilize a state specific error rate for the purpose of imposing fiscal penalties on individual states. Illinois urges CMS to clarify this policy in the next published rules and all future guidance.

4. Duplication of Efforts

- Specifically states are permitted, pending CMS approval, the option of using the MEQC traditional reviews to meet the PERM eligibility requirements for Medicaid. To assist states in understanding the available options, Illinois requests that CMS develop a schematic and/or matrix that compares and contrasts the criteria needed under "traditional" and "pilot" MEQC reviews and PERM review criteria. We believe this will help to minimize confusion about requirements under each option and clarify for states any risks associated with each.

- Illinois recommends that CMS ensure that states who conduct pilots under MEQC and opt to conduct MEQC traditional reviews to satisfy PERM requirements, will have the option to revert to "pilot" MEQC methods in non-PERM review years. To streamline this process and facilitate successful, accurate substitution of the programs, Illinois recommends that CMS provide states with guidelines for the steps entailed in the conversion from traditional to pilot MEQC methods. In addition, we recommend that states retain this substitution option in years when states are chosen for SCHIP eligibility reviews.

- To gain the full impact of burden reduction and meet MEQC reporting requirements we propose that these eligibility reviews (either for Medicaid or SCHIP) be accepted by CMS as MEQC Pilot reviews for a state's PERM years.

- Illinois understands that states can opt to do traditional MEQC "positive" reviews in place of PERM. If negative reviews are to be conducted, we request clarification as to whether this substitution option also will be permitted for "negative" reviews.

- States often experience difficulty when conducting beneficiary eligibility reviews on negative action cases (e.g., denials and terminations) due to the unwillingness of the individuals in the sampled cases to provide requested information and data. States report that the problem is exacerbated by the fact that the state has no legal authority to mandate cooperation. If negative reviews are to be conducted, Illinois requests that CMS allow states to drop negative cases where the individuals are not cooperative.

12. Burden Estimate

- Illinois applauds CMS for revising it estimates to 13,180 hours per state at a program cost per state of $532,340. However, we continue to believe that these estimates do not reflect the entirety of the burden imposed upon states. We estimate the burden in Illinois would be approximately 17,500 hours instead of 13,180 hours at a program cost significantly higher than the $532,340 estimate proposed. In addition, to support the PERM eligibility initiative, it appears that states will need to hire and train additional staff.

Sample Size Development

- Illinois recommends that the sampling measurement be beneficiary based instead of case based. Eligibility of a beneficiary is determined independently of the other case members.

Sampling by case would produce less valid results than sampling by beneficiary and would significantly increase the manpower requirements for the states.

- A negative case is defined as a beneficiary who has completed an application for benefits and is denied or whose program benefits were terminated. Denied and terminated cases do not allow for the payment of Medicaid services. Therefore, negative cases do not meet the purpose of PERM, which is to estimate the dollar amount of payment errors.

Case Reviews

- We believe that payment for services received should not be included in these reviews. 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 rate cannot be produced.

- Illinois is concerned with CMS' decision to exclude an administrative period that is contrary to the procedure in MEQC (see 42 CFR 431.804). MEQC presently allows an administrative period for changes that take place in the review month or the month prior. This period allows the caseworker time to react to the change and provide timely notice. We strongly recommend inclusion of the administrative period to reflect changes in a beneficiary's circumstances when reported in the month prior to the review month to ensure an accurate and reliable eligibility error rate is established.

Illinois encourages CMS to make available as soon as possible anticipated schedules for fiscal year 2007 and each subsequent year in a timely fashion. Advance notice of the PERM schedule deadlines is critical to states' planning, including their organizational and budgetary processes.

Thank you for the opportunity to comment on these important regulations. Illinois strongly supports valid payment accuracy measurement. We also support the new federal initiative, Medicaid Integrity Program (MIP). Illinois encourages the CMS division administering PERM to collaborate with its counterparts who are developing and implementing the MIP to minimize any duplication of efforts and clarify how the programs may overlap and/or interact.

Thank you for your time and attention in this matter. IHFS stands ready to partner with your agency in creating a system that will achieve the goals outlined in our comments.

Sincerely,

Anne Marie Murphy

Anne Marie Murphy, Ph.D.
Illinois Medicaid Director
201 S. Grand
Springfield, Illinois 62763

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Director

July 21, 2006

Rec'd
JUL 25 2006

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development - A
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: Melissa Musotto

Re: Comments to Information Collection Request, "Payment Error Rate Measurement (PERM) of Eligibility in Medicaid and the Children's Health Insurance Program (SCHIP)"
Form Number: CMS-10184 (OMB#: 0938-New)

Dear Ms. Musotto:

The New Jersey Division of Medical Assistance and Health Services respectfully submits the following comments in response to the Notice of Information Collection Request published in the Federal Register on May 26, 2006 and the Supporting Statement retrieved from the CMS web site.

New Jersey was one of the states selected to participate in the workgroup convened by the Centers for Medicare and Medicaid (CMS) to develop and recommend PERM eligibility review methodology. We believe that, with some adjustments, the proposed eligibility methodology could satisfy the Improper Payments Information Act (IPIA) of 2002; but we are still concerned that the State's cost to operate this collection of activity is understated.

Using the traditional MEQC process as the template for the PERM eligibility review has merit. However, the MEQC process has caveats not mentioned or not sufficiently acknowledged in the Supporting Statement. The following comments pertain to the cited sections of the Supporting Statement: Eligibility Error rate Measurement in Medicaid and the State Children's Health Insurance Program.

A. Background

Paragraph Four: CMS requires states to submit their eligibility sampling plans for approval 60 days prior to the federal fiscal year being reviewed. Since the interim final rule concerning PERM eligibility review methodology has not been published; the August 1, 2006 sample plan submission date cannot be met. Will the new submission date shorten CMS' turnaround time for responding to timely submissions? We would need as much advanced notice as possible to make needed modifications and to facilitate resource management.

B. Justification

4. Duplication of Efforts

- An important recommendation made by New Jersey and discussed among the CMS Eligibility Workgroup participants was to allow states the option to use MEQC staff to perform PERM reviews. The PERM eligibility review, like Medicaid pilot projects, would serve as a substitute for the MEQC review: The state's most recently reported MEQC error rate would satisfy MEQC requirements while the state's MEQC staff performed PERM eligibility review duties. Otherwise, to perform PERM and MEQC concurrently would require additional state resources; which would represent a prohibitive increase in cost and burden.

  This section also seems to imply that a state's use of the PERM sampling plan to perform MEQC reviews satisfies both PERM and MEQC reporting requirements. PERM review requirements are fundamentally different than MEQC or our SCHIP quality control (a mock up of MEQC) requirements: The PERM review determines the accuracy of the agency's most recent eligibility decision; the MEQC review determines client eligibility for the review month and makes use of several provisions not adopted for PERM. We are convinced that the rates derived from such a combination may satisfy PERM requirements but be inherently flawed for MEQC reporting.

- Does CMS' approval of the State's PERM sample plan (Medicaid or SCHIP) also provide tacit approval of the State's eligibility review methodology? Or, is there a separate submission requirement? Will a certification statement of compliance from the state Medicaid agency administrator suffice?

- The term "case" usually refers to the "sample unit" that is subject to review. In the interest of keeping the active case review requirements as valid but less stringent than traditional MEQC, we propose that the sample unit be defined as "a person" rather than "persons comprising the eligible unit". Reviewing the individual rather than the group will yield more manageable information and cleaner findings. It would also lessen the complexity of the process of identifying and counting applicable payments, calculating client cost share liability or spousal support if applicable.

7. Special circumstances

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?

12. Burden Estimate (Total Hours & Wages)

CMS estimates that it will cost $532,340.20 per State per program review (Medicaid or SCHIP) and that participating States will spend about 13,180 hours reviewing, analyzing and reporting on approximately 701 cases. Understandably, these are conservative estimates and cannot reflect the staffing and training needs, eligibility processing methodology/complexity, size of travel area/transportation mode, case record accessibility or a variety of other factors that challenge reviewer proficiency.

Case Reviews

The assumptions need clarification and reconsideration.

- While the Administrative Period may not be vital to the PERM eligibility review of stratum 1 and stratum 2 sample cases; to review stratum 3 sample cases without it would exclude significant changes in the client's circumstances when reported in the month prior to the review month.

- In addition to excluding (dropping) active fraud investigation cases from the sample, other cases should be excluded: For example, cases in fair hearing status and cases where the sampled person is discovered to have

SSI eligibility under a different program number. This is not uncommon in 1634 states, where SSI recipients are auto-enrolled into Medicaid.

- PERM eligibility cases are to be reviewed "in accordance with the state's eligibility policies that are in effect as of the review month". Is this the same as reviewing cases against the approved State Medicaid Plan?

C. Collection of Information Employing Statistical Methods

The minimum sample size (501 cases per program) is based on an assumed 5% error rate. We question the validity of using 5% and its applicability to all participating states. If this is an arbitrary figure, why not assume a 3% or 2% error rate? Either assumption would result in a smaller sample and lessen the state's burden without affecting the precision of the findings. Also, does the 5% assumption denote case errors or payment errors?

We appreciate the opportunity to comment on the proposed rules and hope that our comments, questions and recommendations are useful as CMS administrators work toward complying with the IPIA of 2002 requirements. Questions regarding our remarks may be directed to Claude T. Singleton, Bureau of Quality Control at (609) 588 – 2959.

Sincerely,

Ann Clemency Kohler
Director

ACK:CTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID

MICHAEL J. WILLDEN
Director

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Rec'd
JUL 25 2006

July 12, 2006

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Developments-A
Attention: Melissa Musotto
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Information Collection Notice: Payment Error Rate Measurement of Eligibility in Medicaid and State Children's Health Insurance Program (SCHIP)
Form Number: CMS-10184

Thank you for the opportunity to comment on the proposed information collection published by the Centers for Medicare and Medicaid Services (CMS) in the May 26, 2006, Federal Register and the "Supporting Statement: Eligibility Error Rate Measurement in Medicaid and the State Children's Health Insurance Program (SCHIP)". The Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP), as the administrator for Medicaid and SCHIP programs in Nevada, offer the following comments and recommendations:

1. For states with separate SCHIP programs, set up the three year rotation schedule so that both Medicaid and SCHIP reviews are not required in the same federal fiscal year. Requiring states to review both programs in the same year will overburden limited staff and resources and adversely impact the quality of the reviews. It is difficult for states to justify the need for full time staffing when the work is concentrated in one out of every third year. In addition, it is not reasonable to utilize contract staff due to the intense level of training required to perform the eligibility reviews.
2. In addition to item number 1 above, develop an ongoing process to complete 1/3 of the eligibility reviews each year in a three year cycle. This could commence after initial national or state error rates have been developed. This would balance the need for staffing and other resources to complete the eligibility reviews each year. This also would promote system issue identification and remediation in a timely fashion.

3. Provide additional guidance on the program integrity SCHIP regulations found at 42 CFR 457 Subpart I and how SCHIP PERM eligibility reviews can substitute for this requirement. This section is vague and only addresses the states need for processes that allow potential fraud to be investigated.
4. Provide a matrix or other documentation indicating the differences between MEQC and PERM eligibility review requirements and the potential associated penalties for each methodology in order for states to fully access the financial exposure of opting for MEQC reviews to replace PERM reviews in the years when PERM reviews are required.
5. Provide guidance on how best to adjust the MEQC reviews to meet PERM requirements.
6. Program eligibility requirements differ significantly between SCHIP Medicaid expansion programs and stand alone programs. For this reason we request that further eligibility review and error rate criteria guidance be provided to states that have stand alone SCHIP programs.
7. Provide states with as much notification as possible as to when their SCHIP programs will be scheduled for review. This need is especially relevant for programs that are scheduled for review in FFY 2007 since the eligibility sampling plan is due to CMS by August 1, 2006. It is difficult to request sufficient staff and resources to meet the federal requirements for PERM when we do not know exactly when the staff and resources will be needed. The issue of late notification of exact requirements is compounded in states where the State Legislature meets only once every 2 years.

Questions regarding these comments or recommendations should be directed to John A. Liveratti, Chief, DHCFP Compliance Unit at (775) 684-3606 or by e-mail at liveratt@dhcfp.state.nv.us.

Sincerely,

Charles Duarte
Administrator

Cc: Michael J. Willden, Director, Department of Health and Human Services
Nancy Ford, Administrator, Division of Welfare and Supporting Services

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

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July 21, 2006

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JUL 25 2006

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – A
Attention: Melissa Musotto
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7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Agency Information Collection Activities: Proposed Collection — Payment Error Rate Measurement (PERM) of Eligibility in Medicaid and the State Children's Health Insurance Program (SCHIP)

Dear Ms. Musotto:

The State of Montana Department of Public Health and Human Services (MTDPHHS) respectfully submits this comment letter on Medicaid and SCHIP Payment Error Rate Measurement. We are commenting on the agency information collection notice published in the May 26, 2006, *Federal Register* (71 *FR* 30409) for the Centers for Medicare and Medicaid Services (CMS) and the supporting statement providing additional guidance. MTDPHHS has reviewed and commented on all previous versions of the regulations related to the PERM requirements.

We are encouraged that CMS has taken steps to seek consultation from states as it further develops the PERM requirements. We are submitting the following comments and suggestions detailing our remaining concerns and requests for clarification, including:

- Increased collaboration with the States in the development of PERM;
- clarification on the eligibility component of PERM reviews;
- intersection of PERM and other programs that have a fraud and abuse component, including the new Medicaid Integrity Program (MIP);
- cost and funding issues related to PERM;
- definitions of the program integrity requirements as they relate to the SCHIP program; and
- methodology issues related to review of active and negative cases.

As indicated in our previous comments, we believe that CMS' previous announcements and this announcement contain inadequate information to evaluate fully their impact on MTDPHHS.

Our detail comments on the Supporting Statement: Eligibility Error Rate Measurement in Medicaid and the State Children's Health Insurance Program are outlined below:

A. Background

- MTDPHHS wishes to reiterate its strong opposition to any attempts by CMS to utilize the national payment error rates to impose negative fiscal penalties on states. As noted in the Supporting Statement and previous regulatory documents, the Improper Payments Information Act of 2002 requires that CMS produce a national error rate. This statute in no way confers authority to the federal agencies to determine and utilize a state-specific error rate for the purpose of imposing fiscal penalties on individual states. MTDPHHS urges CMS to clarify this policy in its future guidance.

  The PERM program will result in "reviews." MTDPHHS requests that CMS specify whether such reviews will include "findings." If so, how will CMS utilize these findings and what agencies, organizations, individuals, or other entities will have access to such information?

- In the Supporting Statement, CMS indicates that states shall "Review eligibility in the same year that the states are selected for Medicaid or SCHIP FFS and managed care reviews." The use of the word "or" indicates that states will be selected to conduct full PERM reviews (claims processing, medical, and recipient eligibility) for either Medicaid or SCHIP claims/cases, but not both, every third year. MTDPHHS believes this is consistent with CMS' statement on page 4, paragraph 6, which states, "Each year, 17 states will participate in the Medicaid error rate measurement project and 17 states in the SCHIP error rate measurement project." However, this appears to conflict with the statement in the text of the CFR (May 26, 2006), which reads "...each state will be measured for improper payments, in each program, once and only once every three years." MTDPHHS requests that CMS issue clarification so states may determine the process for selection for PERM review.

- The Supporting Statement indicates that states selected for review must submit an initial eligibility sampling plan to CMS for approval 60 days prior to the fiscal year being reviewed. MTDPHHS urges CMS to provide significant time for states to respond to and amend their sampling plan.

- MTDPHHS requests clarification of language in the Supporting Statement that references CMS' process and timelines for notifying states when the managed care, SCHIP, and eligibility components would be included in the PERM review process. For example, will the states be selected for eligibility reviews separately from the selection of states for the other two components? Are SCHIP and MA sampled separately for eligibility reviews? If all three components of PERM are done in a state in the same year, will a separate sample be needed for eligibility reviews, even if all three components are being done at the same time?

- MTDPHHS recommends that CMS waive SCHIP's provision that imposes a 10 percent cap on administrative expenses during the year when a state does its SCHIP PERM review. Montana will need to invest significant resources in administrative costs in the year they are subject to the SCHIP PERM review, and this cap is likely to impede their ability to fully comply with PERM and/or SCHIP regulations.

- MTDPHHS recommends that CMS not subject a single state to PERM reviews of both its SCHIP and Medicaid program in the same year. Montana already faces a number of new burdens associated with the implementation of PERM reviews, including additional staffing and funding resources.

- In addition, MTDPHHS requests 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 are stand-alone programs, rather than a Medicaid expansion program.

- In the Background section, CMS explains the sampling parameters states will use. However, we believe this section conflicts with the text on the same subject on section C, "Collections of Information Employing Statistical Methods." The former indicates a 95 percent confidence interval, using the mid-point of the confidence level, with +/-3 percent precision. The latter indicates a 95 percent confidence level, using the mid-point of the confidence interval, within 3 percent precision. The words "interval" and "level" are used differently on each, prompting the need for clarification. In addition, in section C, CMS indicates that, to estimate the average state sample size, CMS assumed an error rate of 5 percent. Since CMS does not indicate that the states should also assume an error rate of 5 percent when choosing their samples, should states assume that they should calculate sample size without reference to a particular estimate of error, e.g., the mid-point?

- MTDPHHS also recommends that CMS add provisions to the sampling section for adjustments to the sampling plan to adjust for over or under sampling that may occur. The MEQC traditional reviews have such provisions outlined in the handbook.

- MTDPHHS requests that CMS clarify the formula to be used to calculate the state-specific eligibility error rate based on the review results. In addition, we request further clarification for the formula that will be used to calculate the state-specific payment error rate that is uniquely attributable to eligibility errors.

- The Supporting Statement reads that, "States will select monthly samples and conduct the reviews using a CMS standardized review methodology." We are concerned with the unspecified "CMS standardized review methodology." MTDPHHS is aware that recommendations were made by the Eligibility Workgroup and that these are not reflected in the current information released by CMS. MTDPHHS believes it is appropriate for CMS to re-engage states and other stakeholders in reviewing and revising the methodology. In addition, we ask that CMS provide a timeline for when this methodology is expected to be available.

- The Supporting Statement reads that, "Using a standard formula, states will then calculate and report to CMS, state-specific eligibility error rates based on the review results." States request clarification as to the frequency of this reporting of this error rate. For example, will it be reported on a monthly basis or reported at the end of the review? Will the monthly eligibility review results have to be submitted to CMS on a monthly basis? How with the PERM reporting be coordinated with the MEQC reporting for states opting to do traditional MEQC reviews in lieu of PERM?

B. Justification
4. Duplication of Efforts

- MTDPHHS applauds CMS' decision to mitigate any duplication of effort for those states performing traditional Medicaid Eligibility Quality Control (MEQC) reviews and to reduce cost and burden for Montana. Specifically, states are permitted, pending CMS approval, the option of using the MEQC traditional reviews to meet the PERM eligibility requirements for Medicaid. To assist us in understanding the available options, MTDPHHS requests that CMS develop a schematic and/or matrix that compares and contrasts the criteria needed under "traditional" MEQC reviews and PERM review criteria. We believe this will help to minimize confusion about requirements under each option. The supporting statement issued with the May 26, 2006, notice also indicates SCHIP "program integrity requirements" as potentially meeting PERM review. To this end, we recommend that CMS also include SCHIP criteria in any such schematic or matrix.

- MTDPHHS recommends that CMS accept all aspects of traditional MEQC reviews as substitution for PERM reviews, this would include but not be limited to sample size, sample selection methods and stratification, review procedures, error rate determination, etc..

- MTDPHHS also supports recommendations made by states in the CMS Eligibility Workgroup regarding the MEQC–PERM "substitution." Specifically, in states choosing to substitute the MEQC review for the PERM eligibility review, we encourage CMS to accept the state's most recently reported MEQC error rate as meeting MEQC requirements while the state's MEQC staff performed PERM eligibility review duties. MTDPHHS is concerned that without this consideration, states' resources would be further strained by the concurrent requirements of performing PERM and MEQC reviews.

- This section seems to imply that a state's use of the PERM sampling plan to perform MEQC reviews satisfies both PERM and MEQC reporting requirements. However, PERM review requirements are fundamentally different from MEQC or, when applicable, SCHIP quality control requirements. MTDPHHS is concerned that the rates derived from such a combination may satisfy PERM requirements but be inherently flawed for MEQC reporting.

- MTDPHHS understands that states can opt to do traditional MEQC "positive" reviews in place of PERM. We request clarification as to whether this substitution option also will be permitted for "negative" reviews.

- MTDPHHS appreciates CMS' efforts to "make the active case review requirements less stringent than required under the MEQC program." States request additional information on the differences and steps CMS has taken. Specifically, we are interested in how verification requirements have been minimized, what case exclusions from the universe are allowed, and under what circumstances will states be able to cite cases where eligibility cannot be determined as "undetermined"?

- In the Supporting Statement, CMS indicates that "states can cite cases where eligibility cannot be determined as 'undetermined.'" States request that CMS clarify at what point a review would be shown as "undetermined" in the review process and the documentation that CMS will require to demonstrate this.

12. Burden Estimate

- MTDPHHS appreciates that CMS has continued to revise its estimate of the hours required to respond to requests, now 13,180 per state, and the cost per state per program, now $532,340. However, we continue to believe that these estimates do not reflect the entirety of the burden imposed upon states. We base this statement on the fact that the full PERM requirements have not been published and as such the total impact on Montana is unknown.

  Specifically, we urge CMS to further revise its estimates to reflect the staffing and training needs, eligibility processing methodology/complexity, size of travel area/transportation mode, case record accessibility, and the range of other factors that challenge reviewer proficiency.

- MTDPHHS is especially concerned with this additional burden on the state in light of the number of children who will not be able to access health care through the SCHIP program. Assuming an annual cost to the state of $532,000 for PERM the State of Montana would have to reduce the number of children served by 325. While this may not seem significant to CMS, it is a significant concern to the 325 families who will be on a waiting list, additionally, this reduction in the number of children served represents approximately 3% reduction in SCHIP enrollment just to fund the PERM requirements.

- As the number of uninsured people increases, MTDPHHS providers will likely have to shift resources from providing services to responding to PERM administration requests. This creates cost shifting by the providers and creates instability in the provider networks. We recommend that CMS consider the impact of PERM on the provider networks.

- As discussed in our previous comments, budget requests for state staff must be submitted far in advance, considering the state operates on a two-year legislative cycle. The proposed random group of states that will be selected each year may make it difficult to predict what resources a given state will need in advance of the requirement. Unless CMS provides 100 percent funding for additional personnel required under PERM, states may be forced to shift state staff from other budgeted resources to comply with PERM requirements.

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

- As we suggested in our previous comments on the proposed information collection initiative, a solution to the difficulty in estimating states' burdens is for CMS to provide 100 percent reimbursement for staff time and other expenses to comply with CMS' PERM regulations. It seems likely that the first PERM round will be the most onerous, where states essentially are transferring a large body of medical review, systems, and provider information knowledge to PERM contractors. We encourage CMS to consider additional support to states during this startup phase to ensure that the process is workable and that both states and CMS are satisfied that the resulting error rates are valid, consistent, fair, and accurate. Neither CMS nor states will be well served by PERM results that are based on incomplete data, a flawed methodology, or inconsistent application. CMS could avoid considerable criticism by ensuring that states have the resources to adequately support the PERM contractors during the all-important first round.

- MTDPHHS considers PERM to be an unfunded mandate by the federal government. Furthermore, we do not believe that PERM is cost effective when considering the recoveries versus the costs, and we believe this is in conflict with the desire the Medicaid Integrity Program (MIP) objective of providing a Return on Investment. Accordingly, we request CMS conduct analysis to determine if this is an unfunded mandate and if there is a positive cost benefit analysis of PERM.

12.4 Corrective Action Plans

- As we noted in our previous comments, we encourage CMS to enter into a dialogue with states to identify the components of model corrective action plans so that these can be refined and agreed upon before the PERM information collection process begins. We suggest that CMS establish a steering committee or other advisory group that includes state representatives to help ensure that the PERM contractors consider all the logistical issues and address potential data collection issues before beginning their onsite and interactive work with states in collecting medical review policies, manuals, and system documentation. For Montana, obtaining systems documentation is likely to require assistance from our fiscal agent staff, which may involve contracting changes or unanticipated additional support expenses. If state representatives have the opportunity to participate through an advisory or other steering committee, states might be able to assist in reducing the "steep learning curve" facing federal PERM contractors and reduce demands on state staff to support the PERM contractors.

Sample Size Development

- MTDPHHS is concerned with CMS' decision to choose the same number of cases for review by each state regardless of the size and capacity of the state. Does CMS anticipate that all states will review 701 cases for eligibility, regardless of the size of the state caseload? Will there be any sample size differential based on state caseload? We request that CMS reconsider this approach to even out the disproportionate burden this will have on states depending on state caseload and other appropriate factors.

- For states substituting traditional MEQC reviews for PERM, we suggest that all aspects of the MEQC sample size, sample selection methods and stratification, review procedures, error rate determination to substituted for PERM requirements.

- In the Supporting Statement, CMS indicates that the measurement will be "case-based." CMS should be aware that Montana determines the eligibility of the individual first and the eligibility of the case second, specifically with respect to Medicaid family cases. Consequently, it may be more appropriate for Montana to select an "enrollee-based" sample rather than a "case-based" sample. Since the eligibility of each individual enrollee is determined independently of each of the other family members, sample selection by case would produce less valid results than sample selection by enrollee. In addition, it would substantially increase the workload for the staff responsible for conducting recipient eligibility reviews. MTDPHHS requests that CMS clarify if we will be allowed to draw Medicaid samples using enrollees as the sampling unit rather than cases. In addition, if so, we will need additional information regarding how the formula for computing the eligibility review error rate will have to be adjusted to accommodate this modified approach.

- One component of the SCHIP eligibility redetermination allows for provisional redetermination, if a recipient may be eligible for Medicaid. In this event, the recipient is determined provisionally eligible for SCHIP until a Medicaid determination is made. Would these recipients be considered in the redetermination stratification upon their provisional redetermination or upon their final redetermination? Additionally, how should these recipients be handled in if they are selected in the 3rd stratification of the PERM sampling plan? It is our recommendation that these recipients be excluded from all sampling strata while they are in the provisional status.

- It remains unclear in the supporting statement the method Montana should employ for the active and negative reviews and for calculating the state-specific error rate. MTDPHHS encourages CMS to make available resources and technical assistance for states to comply with these requirements. In addition, we recommend CMS issue further details explaining how the federal contractor will calculate the national error rate for Medicaid and SCHIP.

- For the active and negative cases, CMS could assist states by providing eligibility review flowcharts. Such a flowchart would support consistency among the states.

- MTDPHHS also requests clarification on how we should handle cases that are not subject to review or cannot be completed due to non-cooperation of recipient or collateral contact.

In addition, we ask that you explain how these cases will be handled in determining a state's error rate.

- Further, Medicaid and SCHIP providers have up to 12 months to submit a bill for payment. We ask that you address whether a payment error rate will be determined only on bills paid as of the review date.

Case Reviews

- MTDPHHS was pleased to note that CMS added an additional 2,135 hours to the 7,845 case review hours CMS estimated for supporting functions like training, supervision, quality assurance and creation of review tools, etc. However, adequate training of eligibility case reviewers alone would be in excess of 1,000 hours, thus leaving only about 1,000 hours for supervision, coordination, re-reviews, creation of review tools, tracking programs, quality assurance, etc. MTDPHHS strongly recommends that CMS further revise upwards its estimate of case review hours since the current 1,000 hours is not sufficient to accomplish these supporting functions.

- MTDPHHS understands that CMS will soon incorporate the eligibility component in the PERM review process. MTDPHHS requests clarification related to sample selection; if all three components of PERM are done in a state in the same year, will the "eligibility" review component be independent of the reviews for the other two components. That is, will a separate sample need to be drawn for it even if all three components are being done at the same time?

- The CMS Supporting Statement indicates the active cases are divided into three strata: stratum 1 is completed applications for the sample month, stratum 2 is completed redeterminations for the sample month, and stratum 3 is all other active cases. 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 and how provisional redeterminations should be addressed.
    - That is, should applications that are opened as administrative applications, such as reopening following an appeal reversal, be excluded from the universe for stratum 1?
    - Would these applications meet the definition of a completed application for stratum 1?
    - Would reapplications in which a case is reopened following a termination action, such as the case that is incorrectly terminated, be included in the universe for stratum 1 or stratum 2?
    - At what point in time would a provisionally redetermined recipient be considered redetermined, upon final redetermination or upon provisional redetermination?

- We often experience difficulty when conducting recipient eligibility audits on negative action cases (e.g., denials and terminations) due to the unwillingness of the sampled cases to provide requested information and data. The problem is exacerbated by the fact that

the state has no legal authority to mandate cooperation. MTDPHHS requests that CMS clarify the flexibility states will have in dealing with these cases. That is, what criteria will states have to legitimately declare the review of a negative action case "undetermined"?

- Historically, the SCHIP program has focused a great deal of efforts in reducing barriers to enrollment. MTDPHHS has concerns that the PERM requirements are in fundamental conflict with the objective of maximizing health care access for uninsured children.

- CMS assumed that the payment error rate would be determined by using payments for services received in the first 30 days of eligibility for new cases or newly re-certified cases (strata 1 and 2) and in the review month for ongoing cases (stratum 3). Since not all providers bill Medicaid immediately, MTDPHHS recommends that CMS provide states with additional guidance indicating the length of time that they are permitted to obtain this information. In addition, CMS should provide guidance to states as to how they should treat cases with no paid claims for the particular month.

- The Supporting Statement does not address how CMS proposes calculating a payment error rate under managed care or other insurance arrangements.

- The Supporting Statement indicates that CMS will permit states to exclude active fraud investigation cases from the sample. MTDPHHS encourages CMS to exclude other types of cases since they would pose similar challenges in conducting the PERM review, including cases in fair hearing status and cases where the sampled person is discovered to have SSI eligibility under a different program number. MTDPHHS is a 1634 state, where SSI recipients are auto-enrolled into Medicaid, as such we recommend excluding these recipients from the sample. Further, MTDPHHS encourages CMS to exclude cases that are being actively investigated for possible fraud in the food stamp program, the TANF program, the SSI program, etc.

- Montana also requests clarification of "cases under active fraud investigation" which CMS uses to define states' case reviews.

- MTDPHHS disagrees with CMS' decision to exclude an administrative period that is contrary to the procedure in MEQC (see 42 CFR 431.804). For strata 1 and 2, the review is focused on the completed applications and redeterminations in the review month. The PERM review would determine if the completed application or completed redetermination action was correct at the time the action was taken in the sample period; however, the other active cases could have actions in prior months as far back as 12 months. For example, time during which a case may have aid continuing pending a fair hearing on a negative decision, or the period between the decision and the tolling of a federally required timely eligibility notice to the client. It is currently unclear how payments during such periods will be treated. MTDPHHS supports efforts to ensure that the continuing provision of services pending the outcome of a hearing or the clockdown of a case closing would not count against the state, if the eligibility decision was correct.

In addition, under certain circumstances, MEQC presently allows an administrative period for changes that take place in the review month or the month prior. This period allows the caseworker time to react to the change and provide timely notice without being cited in error. Montana supports inclusion of the administrative period, specifically for stratum 3 cases, to ensure that the review reflects changes in clients' circumstances when reported in the month prior to the review month.

- MTDPHHS appreciates CMS' efforts to coordinate the Medicaid and SCHIP PERM requirements. However, we remain concerned with a number of inconsistencies or lack of information in the notice that is critical to states meeting the PERM requirements. The Medicaid and SCHIP program do not always have corresponding "program integrity requirements." As such, we ask CMS to further clarify the guidelines that states may use to ensure their SCHIP programs can be appropriately substituted for PERM.

Collections of Information Employing Statistical Methods

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

Miscellaneous

- Several new projects and initiatives are now underway at the federal and state levels. As with the MEQC program, although distinct, many of these initiatives have overlapping goals and functional steps for implementation. Specifically, the new MIP is likely to have some overlap with PERM. MTDPHHS encourages the CMS division administering PERM to collaborate with its counterparts who are developing and implementing the MIP to minimize any duplication of efforts and clarify how the programs may overlap and/or interact. MTDPHHS asks that CMS indicate whether the PERM review results will be provided to the new MIP and how such findings might be used.

- MTDPHHS suggests that CMS consider a performance bonus arrangement for the states that operate effective and efficient Medicaid and SCHIP operations. The Food Stamp program operates under a performance bonus model that could be applied to Medicaid and SCHIP to reward states with effective operations.

- MTDPHHS continues to have significant concerns with the claim review aspects of PERM (adopted in November 2005) and would like to participate in on-going discussions with CMS and other states regarding the actual results of the reviews currently underway.

We would be pleased to meet with you at any time on these matters. Thank you for considering our comments. If you have any questions, please do not hesitate to contact me at (406) 444-4084.

Sincerely,

Duane Preshinger for John Chappuis

John Chappuis
Deputy Director and State Medicaid Director
State of Montana
Department of Public Health and Human Services

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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July 21, 2006

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7500 Security Boulevard
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Part 5
JUL 25 2006

Attention: Melissa Musotto, Room C4-26-05

Re: PERM Eligibility Review Comments - 5/26/06 NPRM

Dear Ms Shortt:

Thank you for the opportunity to provide comments on the PERM eligibility proposed rules published on May 26, 2006, page 30410 of the Federal Register, Vol. 71, No. 102. It should be noted that the formal notice of rulemaking is less than one half page long, which is of serious concern given the complexity of the PERM program and the significant impact it will have on states. Due to the lack of detail regarding PERM in the May 26, 2006 Federal Register, the following comments, suggestions and questions address the Supporting Statement: Eligibility Error Rate Measurement in the Medicaid and the State Children's Health Insurance Program found as a document in file CMS 10184 on the CMS website.

Please also note that interim final regulations published October 5, 2005 responded to comments submitted for PERM regulations originally published on August 27, 2004. Virtually all CMS responses deferred details regarding eligibility reviews to a workgroup that had yet to be convened. The purpose of the workgroup was to create plans and details for PERM eligibility reviews. The Supporting Statement cited above is the product of that workgroup. The lack of details and specifics in the Supporting Statement is disappointing. It is more than challenging to submit meaningful comments when the PERM roadmap is so vague. Consequently, some of the comments herein are based on conjecture rather than a clear PERM proposal from CMS.

Stratified Sampling

The proposal calls for a stratified sample consisting of 1/3 new openings, 1/3 redeterminations of eligibility and 1/3 ongoing cases. Presumably, to accomplish the ratios required, a state would have to estimate the annual numbers of opening and redetermination actions, calculate an interval, compile the frames each month and draw samples. The on-going cases would consist of all remaining cases in the universe of all Medicaid cases open at some time during the month. While it is understood that reviewing recent eligibility actions can be done with greater ease, this sampling approach raises some concerns. This approach is a difficult way to sample. The programming needed will be time consuming and expensive. Furthermore, New Hampshire's "New Heights" eligibility system's scheduled maintenance, enhancements budget and staffing have already been stretched thin by TANF reauthorization and other priorities. Tasks have been finalized for the next year. Programming for stratified sampling will impinge upon other program administration.

In addition, CMS has not addressed statistical validity in this approach. Will there be weighting to balance proportions to the three populations? The stratification approach also poses some methodology issues because it is entirely possible that the same action will be sampled more than once during the FFY.

Dropping Cases

Interim/final regulations published October 5, 2005, responded to comments regarding dropped cases due to death or non-cooperation of assistance group members by stating this matter would be clarified in a subsequent issuance. This issue was not addressed in either the May 26, 2006 Federal Register or the Supporting Statement. Additionally, there are other factors such as the assistance group leaving the state, inability to locate the assistance group, or lost eligibility records which all could be valid reasons for not considering a case subject to review. It should also be noted that the stratified sampling requirement would result in cases being sampled for a review of the same eligibility action more than once during the FFY. For example, would a case drawn for review of an opening action in November be subsequently reviewed for the same action when sampled in March from the frame of active ongoing cases?

Sample Sizes

The sample sizes for all states, regardless of population size, are the same: 200 negatives and 501 active cases. The Supporting Statement offers no rationale for how these numbers were derived. It would seem that a smaller sample size should be required for a small population state such as New Hampshire.

The proposed sample sizes represent a small impact in a large state with vastly more program staff while in a small state, staffing is a far more significant issue. If a large state must only do 501 active reviews, then a small state should be required to review far fewer cases. To satisfy the Improper Payments Information Act, the statistical validity need only be at the national level so statistical validity need only be for the larger national sample.

Logistics

The first bullet, 4th paragraph of the Background Section in the Supporting Statement, mandates that states "[r]eview eligibility in the same year the states are selected for Medicaid or SCHIP FFS and managed care reviews." However, throughout the rest of the document, there are consistent references to 17 states doing SCHIP eligibility and another 17 states doing Medicaid eligibility each year. It is hoped that this is an assurance that no one state will be subjected to both Medicaid and SCHIP claims reviews and, consequently, eligibility reviews in the same year. If eligibility reviews are required for both groups in the same year, states will face significant staffing challenges. The likelihood of states, particularly small states, acquiring the necessary staff and operating the program one year out of three is highly unlikely.

Review Methodology

According to the Supporting Statement, because the eligibility review would focus only on the most recent opening action or redetermination of eligibility there will be no "administrative period." The Supporting Statement appears to presume review methodology would be standardized, but other than mention of the "administrative period," the proposal contains no details regarding methodology.

It is difficult to determine from the Supporting Statement whether error rates will be case error rates or dollar error rates. If the error rates are going to be dollar error rates, for which month will claims be collected? The sample month for an on-going case where the eligibility action being reviewed is several months earlier may have been in error at the time of application. However, there may have been an interim event that corrected the error. Will the interim event be taken into consideration if claims are being collected for the sample month?

Options

CMS has proposed, as an alternative, that traditional MEQC could be substituted for PERM at a state's request and with CMS approval. This is in response to

concerns regarding state resources and duplication of effort raised in earlier comments. The option to substitute MEQC is intended to provide a cost neutral alternative for states facing the gravest difficulties acquiring the resources to do the PERM reviews. However well intentioned this alternative may be, it has the effect of pushing the smallest states with the fewest resources toward doing MEQC and potentially facing the attendant fiscal sanctions.

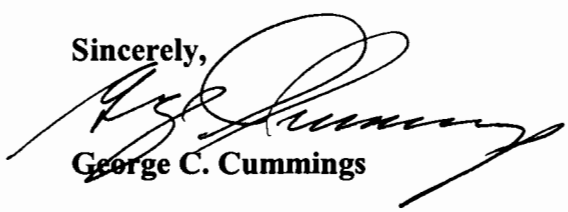
For more than a decade, pilots have satisfied the MEQC requirement for the majority of states. If it is entirely within the power of CMS to approve these pilots, then it is equally possible for CMS to approve PERM eligibility reviews in lieu of MEQC. It seems that this would accomplish CMS's stated intent not to increase the administrative burden on states, while providing all states the same options.

Implementation Timeframes

In conclusion, it is suggested that FFY 2007 PERM eligibility reviews be initiated beginning with the April 2007 sample month and the first year of PERM eligibility reviews be limited to the last two quarters of the FFY. This would allow the first six months of the year to be dedicated to the further planning and development needed to implement an effective and credible PERM eligibility system.

If you have questions, wish further clarification of our comments or we can provide further recommendations, please contact George Cummings, Administrator of the Quality Assurance Unit in our Bureau of Improvement and Integrity at 606-271-4253, gcummings@dhhs.state.nh.us, or at the above address.

Sincerely,



George C. Cummings