Supporting Statement for Information Collection of Medicaid and State Children's Health Insurance (SCHIP) Managed Care Claims and Related Information

A. Background

The Improper Payments Information Act (IPIA) of 2002 (Public Law 107-300) requires CMS to produce national error rates in the Medicaid program and the State Children's Health Insurance Program (SCHIP). To comply with the IPIA, CMS will engage a Federal contractor to produce error rates in Medicaid managed care and SCHIP managed care.

Beginning in 2007, CMS will use a rotational approach to review up to 18 States for each program, for a total 36 States each year. CMS has completed the State selection process for the Medicaid improper payments measurement. States have not yet been selected for the measurement of improper payments in SCHIP. CMS expects to select the SCHIP States in the fall of 2006. Following is the list of States in which CMS will measure improper payments over the next three years in Medicaid.

States Selected for Medicaid Improper Payment Measurements

FY 2006	Pennsylvania, Ohio, Illinois, Michigan, Missouri, Minnesota, Arkansas, Connecticut, New Mexico, Virginia, Wisconsin, Oklahoma, North Dakota, Wyoming, Kansas, Idaho, Delaware
FY 2007	North Carolina, Georgia, California, Massachusetts, Tennessee, New Jersey, Kentucky, West Virginia, Maryland, Alabama, South Carolina, Colorado, Utah, Vermont, Nebraska, New Hampshire, Rhode Island
FY 2008	New York, Florida, Texas, Louisiana, Indiana, Mississippi, Iowa, Maine, Oregon, Arizona, Washington, District of Columbia, Alaska, Hawaii, Montana, South Dakota, Nevada

B. Justification

1 . Need and Legal Basis

CMS needs to collect capitation payment information from the selected States so that the federal contractor can draw a sample and review the managed care capitation payments. CMS will also collect State managed care contracts, rate schedules and updates to the contracts and rate schedules. This information will be used by the Federal contractor when conducting the managed care claims reviews. Sections 1902(a)(6) and 2107(b)(1) of the Social Security Act grants CMS authority to collect information from the States.

The IPIA requires CMS to produce national error rates in Medicaid and SCHIP, including the managed care component. The State-specific Medicaid managed care and SCHIP managed care error rates will be based on reviews of managed care capitation payments in each program and will be used to produce national Medicaid managed care and SCHIP

managed care error rates.

2. Information Users

The information collected from the selected States will be used by Federal contractors to conduct Medicaid and SCHIP managed care data processing reviews on which State-specific error rates will be calculated. The quarterly capitation payments will provide the contractor with the actual claims to be sampled. The managed care contracts, rate schedules, and updates to both, will be used by the federal contractor when conducting the managed care claims reviews.

3. Use of Information Technology

This information collection involves the use of electronic submission of information to the extent that States have the technological capability. CMS will not require States to provide information electronically if they do not have secure systems in place to do so. The collection of information does not require a signature from respondents.

4. Duplication of Efforts

CMS does not approve SCHIP managed care contracts and rates, therefore, we do not have this information on-hand. This information must be collected directly from the States and does not duplicate other collection of this information. For Medicaid, CMS approves managed care contracts and should be able to obtain these and other supporting information from its regional offices to the extent that the regional offices have the current information. The claims data information for Medicaid and SCHIP can only be obtained from the States.

5. Small Businesses

The collection of information does not impact small businesses or other small entities.

6. Less Frequent Collection

Failure to acquire this certification form will prevent CMS from effectively measuring and producing State-specific and national managed care error rates in Medicaid and SCHIP. As a result, CMS will be out of compliance with the IPIA.

7. Special Circumstances

CMS does not anticipate that States will be required to submit information more than initially and once a quarter in the year the States are reviewed. States will provide capitation payment information on a quarterly basis for a one-year period, once every three years.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice for this information collection published on February 3, 2006.

An interim final rule was published on October 5, 2005, which is included in this package in PDF format. In this interim rule, on page 58261, CMS solicited comments on how best to determine an error rate for managed care in Medicaid and SCHIP. Very few comments were received in regards to the managed care measurement. Commenters believed that the managed care methodology should focus on: 1) the beneficiary's eligibility for the managed care organization at the time the capitation payment was made; and 2) verification that the capitation payment was issued in the correct amount. Other comments were that the guidance for the PERM pilot managed care reviews served as a thorough and appropriate methodology to conduct managed care reviews. One commenter expressed concerns regarding the potential cost increase to the provider, due to the medical reviews, indicating that the increased burden may erode provider participation in managed care programs. The federal contractor will perform managed care reviews based on the methodology used in the PERM pilot project. Therefore, the federal contractor will not perform medical reviews in the managed care component so providers will not be required to submit medical records for managed care reviews.

9. Payments/Gifts to Respondents

There is no provision for any payment or gift to respondents associated with this reporting requirement.

10. Confidentiality

Confidentiality has been assured in accordance with section 1902(a)(7) of the Social Security Act.

11. Sensitive Questions

No questions of a sensitive nature shall be asked.

12. Burden Estimates (Hours & Wages)

On a rotational basis, CMS will measure Medicaid and SCHIP managed care improper payments in up to 18 States per program. Therefore, the number of respondents is up to 36 States (18 States for Medicaid and 18 States for SCHIP), per year.

We estimate that an average of 500 managed care capitation payments, per program, are needed from each State to produce a State-specific error rate that meets the CMS required confidence and precision levels. The estimated 500 managed care capitation payments will

be sampled over a full fiscal year selecting a proportional number of payments each quarter. The proportion will be determined by the State's quarterly capitation expenditure data.

The annualized number of hours that may be required to respond to requests for information is 11,700 hours per program (650 hours x 18 States). Using the 2006 general GS-12-01 rate of pay ($26.53/hour) the total cost will be $310,401 per State, per program.

It is estimated that each State will spend up to 650 hours of time annually, per program, to support the collection of this information. While CMS will instruct its federal contractor to obtain the Medicaid managed care contract and rate-setting information directly from the CMS regional offices, it is possible that this information may be unavailable (e.g., outdated, misplaced, or destroyed). In these instances, the contractor will request the information directly from the State. For SCHIP managed care, CMS does not approve the contract and rate-setting information, therefore, these documents are not located in-house. As a result, the contractor will need to obtain this information directly from the State. For purposes of estimating the burden and cost, we will assume that States will submit the managed care contract and rate setting information for both programs although, for the above reason, we do not anticipate States will need to submit Medicaid managed care information in every instance. Beyond these estimates, we do not anticipate additional cost or burden on the States for submitting this information since it is in-house and current State staff will be able to provide this information. The collection of this information does not require knowledge or expertise beyond staff level experience. Information to be collected throughout the year, is as follows:

- Quarterly capitated payment data for the four quarters of the fiscal year being measured (up to 10 hours per quarter, for a total of 40 hours per year);
- Managed care coverage and rate-setting policies in effect at the time of the State selection to be submitted once at the beginning of the year being measured (up to 10 hours per year);
- Updates or amendments to the managed care coverage and rate-setting policies, to be submitted at the end of each quarter (up to 10 hours per quarter, for a total of 40 hours per year); and
- Any repricing payments, as needed (up to 15 hours per quarter, for a total of 60 hours per year).

States will also be required to prepare and submit corrective action plans after error rates are determined for each component and program. For example, Virginia is selected in FY 2006. Its error rate is calculated in August 2007. Viriginia's corrective action plan will be submitted August 1, 2008, which provides the State time to analyze the findings, develop corrective actions, and submit the plan. The total estimate for preparing a corrective action plan addressing managed care errors is 500 hours per State, per program beginning in the third year of this project.

The following assumptions were used:

- In order to meet the State-level confidence and precision requirements outlined in the regulation, we estimated that 500 capitation payments are needed from each State.
- The estimated 500 capitation payments will be sampled over a full fiscal year by selecting a proportional number of capitation payments each quarter. The proportion will be determined by the State's quarterly capitation expenditure data.
- The federal contractor will need managed care coverage and payment policies to review claims.

The total burden for this information collection request is 23,400 hours.

13. Capital Costs

There are no capital costs associated with this collection of information.

14. Cost to Federal Government

The federal government will engage a national contractor to determine the error rate for both Medicaid and SCHIP managed care. Approximately 500 capitation payment claims will be reviewed, per program, per State. The total estimated project cost for the federal contractor to measure managed care in Medicaid and SCHIP is $6.64 million, per year ($3.32 million per program).

15. Changes to Burden

This is not applicable as it is a new requirement.

16. Publication/Tabulation Dates

The calculated national error rate for both Medicaid and SCHIP will be published annually in the Performance and Accountability Report (PAR).

17. Expiration Date

This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement

There are no statistical aspects of the certification form.

C. Collections of Information Employing Statistical Methods

1. The universe for this project is the 50 States' and the District of Columbia's Medicaid and

SCHIP programs.

The respondent universe is up to 36 unique States (up to 18 Medicaid States and 18 SCHIP States). It is estimated that 500 capitation payments, from each selected State in each program, will be randomly selected to achieve a State-specific, program-specific error rate. These results will be used to calculate a national error rate.

The anticipated response rate is 100 percent due to the statutory requirement that provides CMS with the authority to collect information.

2. CMS determined an average claim sample size of 500 capitation payments per State using an assumed error rate of two to three percent. We assumed this error rate based on the Payment Accuracy Measurement and Payment Error Rate Measurement pilot project results. The program level error rate for each State was estimated to achieve a 95 percent confidence level within three percent precision.

3. We expect to get reliable responses because the States are required to report under section 1902(a)(6) of the Social Security Act.

4. Not applicable.

5. Statisticians from The Lewin Group were consulted on the statistical methodology of this project.