Supporting Statement – Part A

Supporting Statement For Paperwork Reduction Act Submissions

A. Background

The Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and State Children's Health Insurance Program (SCHIP). To comply with the IPIA, CMS will engage a Federal contractor to produce the error rates in Medicaid and SCHIP. The error rates for Medicaid and SCHIP are calculated based on the reviews on three components of both Medicaid and SCHIP program. They are: Fee-for-service claims medical reviews and data processing reviews, managed care claims data-processing reviews, and eligibility reviews. Each of the review components collects different types of information, and the state-specific error rates for each of the review components will be used to calculate an overall state-specific error rate, and the individual state-specific error rates will be used to produce a national error rate for Medicaid and SCHIP. The managed care claims data is collected under OMB 0938-0994 (CMS – 10178) and the eligibility data is collected under OMB 0938-1012 (CMS – 10184).

OMB 0938-0994 (CMS – 10178) authorizes CMS to collect captitation payments information from the states for the purpose of measuring improper payments in Medicaid and SCHIP in compliance with the IPIA requirement. The information collected will be used to conduct Medicaid and SCHIP managed care data processing reviews as part of the state-specific error rates.

OMB 0938-1012 (CMS – 10184) authorizes CMS to collect forms for the eligibility review which collects sampling plan, monthly sample lists, review findings, payment findings, summary findings, eligibility error rates and corrective action report. Since the states conduct their own eligibility reviews, we collect their findings to calculate part of the state-specific error rates.

The states will be requested to submit, at their option, test data which include full claims details to the contractor prior to the quarterly submissions to detect potential problems in the dataset to and ensure the quality of the data. These states will be required to submit quarterly claims data to the contractor who will pull a statistically valid random sample, each quarter, by strata, so that medical and data processing reviews can be performed. State-specific error rates will be based on these review results.

For this collection OMB 0938-0974 (CMS – 10166), CMS needs to collect the fee-for-service claims data, medical policies, and other information from states as well as medical records from providers in order for the contractor to sample and review adjudicated claims in those states selected for medical reviews and data processing

reviews. Based on the reviews, state-specific error rates will be calculated which will serve as part of the basis for calculating national Medicaid and SCHIP error rates.

The three collections within this program collects information for the different reviews in the program.

B. Justification

1. Need and Legal Basis

The collection of information is necessary for CMS to produce national error rates for Medicaid and SCHIP as required by Public Law 107-300, the IPIA of 2002.

2. Information Users

The information collected from the states selected for review will be used to conduct claims reviews on which state-specific error rates will be calculated. The current fiscal year's quarterly claims data will be used by the Federal contractor to determine sample size and to sample claims for reviews. The medical policies will be used by the contractor to guide the medical review of the claims. Providers within the selected states whose claims were sampled for review will submit medical records on which the medical reviews will be based. The review findings will be used to calculate state-specific error rates on which national error rates for Medicaid and SCHIP will be calculated.

The optional submission of test data will be used by the Federal contractor to detect potential concerns in the data sets to be submitted by the states to help avoid delays in the PERM measurement operation process.

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 or providers to provide information electronically if they do not have secure systems in place to do so. While most states have claims information electronically, some states will likely submit information regarding claims in a hard copy format such as a tape. The percentage expected to be received electronically is less than 1 percent. The collection of information does not require a signature from the respondents.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

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

6. Less Frequent Collection

Failure to acquire this data will prevent CMS from effectively measuring state-specific payment error rates on which to base national error rates for Medicaid and SCHIP.

Consequently, CMS will not able to produce error rates in a timely manner and would cause CMS to be out of compliance with IPIA.

7. Special Circumstances

CMS does not anticipate that states would be required to submit information more often than quarterly. States will provide quarterly claims data at the end of each quarter. States will also be required to submit medical policies at the beginning of being selected and updates on a quarterly basis at the end of each quarter. Submission of test data is optional.

8. Federal Register / Outside Consultation

The 60-day Federal Register notice published on July 25, 2008.

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. This section provides safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. Any disclosure of information will be strictly for the use of the approved procedures.

11. Sensitive Questions

No questions of a sensitive nature are asked.

12. Burden Estimate (Total Hours & Wages)

The number of respondents is estimated to be up to 34 states (17 Medicaid and 17 SCHIP programs per states). The annualized number of hours that may be required to respond to requests for information equals 28,560 hours (840 hours per state, per program) at a GS-12 step one rate of pay for a total cost of $789,684.

It is estimated that each state will spend up to 840 hours annually, per program, to support this collection of information. The states will provide claims data on a quarterly basis for the following requests, per program:

- i. FY Quarter 1, Test data includes universe data and complete claim details for complete quarter 2 or most recent complete quarter data from the prior fiscal year (up to 20 hours), adjudicated claims data for the current quarter (up to 10 hours), policy in effect at the time of state selection (up to 10 hours) and policy updates at the end of the current quarter (up to 10 hours). This would be four (4) total responses per state, per program for an estimated time of 50 hours per state, per program.
- ii. FY Quarter 2, 3, and 4, Claims data and policies for the current quarter. This would be 2 total responses each quarter, per program, for a total estimated time of 20 hours per state, per program, per quarter.
- iii. States will also be required to provide ad hoc information to:
    1. Re-price claims determined to be in error for a total of 200 hours per state, per program. Errors are expected in less than 10 percent of sampled claims or < 100 requests at an estimated time of two hours per request;
    2. Inform the contractor of claims that were included in the sample but the adjudication decision changed due to the provider appealing the determination and the state overturning the claim, for a total of 20 hours per state, per program. (The appeals process is part of the state's customary and usual course of business.) Adjudication decision changes are expected in less than 2 percent of sampled claims or < 20 requests and an average of one hour per request; and
    3. Inform the contractor of provider enrollment information to assist in finding a provider associated with a sampled claim so that documentation can be obtained for a total of 10 hours per state, per program. It is expected that the contractor use common resources such as the internet, the phone book, and directory assistance before consulting the state. Erroneous provider demographic information, where resources other than the state are not available, is expected rare and estimated in less than 1 percent of sampled claims or < 10 requests.
- iv. States will also be required to prepare and submit corrective action plans after error rates are determined for each program. This will be a single submission in the third year after state selection. Example, a state is selected in FY2006, the error rate can be calculated and reported only after FY 2006 is concluded. The corrective action plan is completed in December 2008. The total estimate for preparing a corrective action plan is 500 hours per state, per program beginning in the third year of this project.

The total burden per state per program is estimated to be 840 hours, of which 780 hours is estimated for reporting burden and 60 hours is estimated for record keeping burden. It was determined that the request for medical documentation to substantiate claim submission is not a burden to individual providers nor is the request outside the customary and usual business practices of a Medicaid and/or SCHIP provider. It is

highly unlikely for a provider to be selected more than once, per program, per year to provide supporting documentation and due to the timeliness of the request for documentation, that information should be readily available and responses should take minimal time. Therefore, this request for information from providers is within the customary and usual business practice of a provider who accepts payment from an insurance provider whether it is a private organization, Medicaid or SCHIP.

The following assumptions were used:

- The estimated number of states needed to produce a national error rate with the confidence and precision to meet the IPIA is up to 34 annually; 17 for Medicaid and 17 for SCHIP.
- The estimated number of claims needed from each state to produce a state specific error rate with the confidence and precision needed to meet IPIA standards is estimated to be 1,500 per program.
- These 1,500 claims are going to be further stratified, based on dollar amount.
- The 1,500 claims will be sampled over a full fiscal year of adjudicated claims by sampling a weighted number of claims each quarter, with the weight determined by quarterly expenditure data.

13. Capital Cost

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

14. Cost to the Federal Government

The Federal Government is going to engage a national contractor to determine the error rate for both Medicaid and SCHIP. The Fee-for-service (FFS) reviews are estimated to cost $7,537,874 per program based on an average of 1,000 claims reviewed. The estimate for 34 responses would cost $15,075,748. The cost associated with submitting information will cost for 34 responses will cost $1,321,185. The total cost for FFS reviews is $16,396,933.

The Managed Care reviews are estimated to cost $4,748,718 for 34 responses based on an average of 500 claims per program. It is estimated that $526, 853 will be used for cost to respond requests for 34 responses. The total cost for MC reviews is $5,275,571.

The total cost to the Federal Government for this collection will be $21,672,504.

15. Changes to Burden

This is a revision of a current approved collection with minor adjusted information requirement collection. There is a 10-hour increase in burden per State per program as part of a new process. Based on the past experience in PERM operation, the adjustment is made to ensure the quality of the data will comply with the data requirement during the measurement.

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.