SUPPORTING STATEMENT FOR
MEDICARE SECONDARY PAYER
INFORMATION COLLECTION AND
SUPPORTING REGULATIONS IN 42 CFR 411.25, 489.2, and 489.20

A. Background

The Centers for Medicare & Medicaid Services (CMS) is seeking to renew approval to collect information from beneficiaries, providers, physicians, insurers, and suppliers on health insurance coverage that is primary to Medicare. Collecting this information allows CMS to identify those Medicare beneficiaries who are in situations where Medicare is statutorily required to be a secondary payer, thereby safeguarding the Medicare Trust Fund. The annual savings from the Medicare Secondary Payer (MSP) program for Parts A, B, and D exceeded $5.4 billion in FY 2007, and CMS anticipates such savings to increase when Mandatory Insurer Reporting begins on January 1, 2009.

1. Purpose

The purpose of this submission is to transmit CMS's supporting statement to the Office of Management and Budget (OMB) for approval of CMS' MSP information collection requirements. With the creation of Medicare Part D under the Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (MMA), the MSP collections have been expanded, where relevant, to include questions about prescription drug coverage.

MSP is essentially the same concept known in the private insurance industry as coordination of benefits, and refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary.

Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation (including Black Lung) benefits. Medicare was also precluded from making payment for services paid for by the Department of Veterans Affairs or other governmental entities. Since 1980, a series of changes in the Medicare law has resulted in additional situations where Medicare is the secondary payer for Medicare-entitled individuals:

- who are age 65 or older and working (hence the term, working aged) with coverage under an employer-sponsored group health plan (GHP), for an employer with 20 or more employees;
- who are age 65 or older and with coverage under a working spouse's employer-sponsored GHP, for an employer with 20 or more employees (the working spouse can be any age);
- with coverage under automobile, no-fault, or liability insurance;

- with kidney failure during the first thirty (30) months of Medicare eligibility if they have coverage under an employer-sponsored GHP, whether it is coverage provided under their own GHP or as the spouse or dependent of an individual with GHP coverage; or
- who are disabled and have coverage under their own GHP because they are still considered to be employed or who are disabled and have coverage under the GHP of an employed family member. (The employer must have 100 or more employees or the plan belongs to a multi-employer plan where at least one employer has 100 or more full or part-time employees.)

The MMA created prescription drug coverage under Medicare Part D and extended the MSP provisions to that coverage. As such, CMS added questions about whether a beneficiary's other coverage includes drugs, and, if so, 1) what the coverage effective dates are and 2) what information identifies the drug benefit plan and the beneficiary in that plan.

2. The Federal Role

The CMS is responsible for managing the implementation of the various MSP provisions of the Social Security Act (the Act). In this role, CMS educates others about the laws and issues regulations, policy, and operational guidelines to implement these laws. To administer Parts A and B, CMS contracts with health insuring organizations, known as Medicare Fiscal Intermediaries (FIs), carriers and Medicare Administrative Contractors (MACs), to process Medicare claims. To administer Part D, CMS contracted with entities known as Part D plans (comprised of Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug (MA-PD) plans) to administer Part D benefits. The MMA extended current MSP laws to Part D; thus, the Part D plans are to pay secondary in MSP situations and are to recover MSP-related overpayments. To comply with the secondary payer laws, the Part D plans must know about: a) the existence of a situation that would make Medicare the secondary payer if another payer exists (*e.g.*, the beneficiary is actively working) and b) the existence of such other payer (*e.g.*, the actively working beneficiary's employer group health plan). The CMS expanded its existing MSP collection to include prescription drug information in order to provide the Part D plans with that information. CMS currently: 1) charges its FIs, carriers and MACs with various tasks to detect MSP cases, 2) develops and disseminates tools to enable them to better perform their MSP-related tasks, and 3) monitors their performance in achievement of their assigned MSP functions. The Part D plans are required to achieve the same goals as the FIs, carriers and MACs, and CMS provides the Part D plans with similar assistance.

3. Monitoring Program Implementation and Savings

Because some Medicare FIs, carriers, MACs, and some Medicare Part D plans currently market health insurance products that may have liability when Medicare is

secondary, the MSP provisions create the potential for conflict of interest. This is particularly the case under Part D because Medicare has a payment burden of 80% after a beneficiary reaches the benefit's catastrophic threshold by fulfilling his or her True Out-of-Pocket (TrOOP) requirements. Recognizing this inherent conflict, CMS has taken steps to ensure that its FIs, carriers, MACs, and Medicare Part D plans process claims in accordance with the MSP provisions regardless of what other insurer is primary.

The CMS monitors performance of Parts A, B, and D MSP functions through contractor performance evaluations. Under this formal evaluation program, FIs, carriers and MACs must meet certain performance standards. MSP savings in Parts A, B, and D have grown over the years and CMS expects that MSP savings will continue to increase over the next several years as compliance with the MSP provisions grows and as Medicare contractors gain greater expertise in detection of MSP cases.

B. MSP Information Gathering Process

MSP information is collected at various times and from numerous parties during a beneficiary's membership in the Medicare Program. Collecting MSP information timely means that claims are processed correctly the first time, decreasing the costs associated with adjusting claims and recovering mistaken payments. Collecting information early is particularly crucial for providing Medicare pharmacy benefits because claims are adjudicated in real time at the point-of-sale. Mere minutes between a beneficiary's appearing at the pharmacy counter and the Part D plan learning of an MSP situation can be the difference between rejecting a primary claim and having to recover money already spent and adjust a beneficiary's TrOOP level and/or progression through the benefit. Part D plans are required to provide pharmacies with the billing information for the primary plan when the Part D plan is aware that Medicare is the secondary payer. For all Parts A and B claims, the provider, physician, or supplier completing the Medicare claim for payment must indicate if other insurance is primary to Medicare (this will not be done at pharmacies for Part D due to the time issue discussed above, but pharmacies will have access to a query database that can help determine the identity of any primary payers). Identifying these primary payers prior to billing requires an accurate MSP determination that can be accomplished by gathering correct answers to the MSP questions. The various information-gathering processes that CMS uses (and will be used relative to Part D) are outlined below.

1. Coordination Of Benefits Contractor (COBC) Processes

<u>The Initial Enrollment Questionnaire Process</u>

Under the Initial Enrollment Questionnaire (IEQ) process, the COBC conducts MSP development for all new beneficiaries within three (3) months of their Medicare

entitlement. This provides CMS with MSP information before any claims are processed, which allows proper billing and payment order from the very beginning. The COBC gathers and processes this information instead of having each Medicare FI, carrier, and Part D plan do so because having only one contractor do the work results in a streamlined, uniform, less costly process.

Each month, CMS provides the COBC with an electronic file containing beneficiary entitlement information. This file serves as the basis for the IEQ mailings and is called the Beneficiary Membership Attainment Record. Previously, if a beneficiary did not respond to the IEQ within thirty (30) business days of the initial mailing, the COBC sent a follow-up IEQ. Beginning in FY 2006, CMS discontinued the follow-up MSP development mailings due to budgetary constraints. A beneficiary that does not respond to the initial IEQ are no longer sent further mailings, unless the beneficiary requests one.

The IEQ mailing contains information about Medicare, the rules governing the liability of other insurers, the IEQ, and a pre-addressed return envelope. The IEQ solicits information about beneficiary insurance coverage that may be primary to Medicare.

The IEQ process uses standard questionnaires that were developed in consultation with a small beneficiary focus group, approved by OMB, and improved based on beneficiary feedback. There are five different IEQs, each one related to a specific category of Medicare entitlement: (1) beneficiaries age 65 or over, (2) disabled beneficiaries, (3) beneficiaries with End Stage Renal Disease (ESRD), (4) beneficiaries with childhood disabilities, and (5) disabled widows or widowers. There are English and Spanish versions of each of these IEQ versions.

These questionnaires ask about situations that trigger secondary payer status, such as whether the soon-to-be beneficiary is actively working; if any such situations exist, they also ask for information about any other coverage that pays for health claims. The questions relating to GHP coverage now include asking whether any such coverage pays for prescription drugs and, if so, what coverage dates and drug-benefit specific identification information may apply. Questions asking about "non-GHP" primary coverage - worker's compensation, automobile, no-fault, or liability coverage - do not specifically ask about prescription drug coverage as those types of coverage always include prescription drugs prescribed for injuries/illnesses/conditions related to the relevant incident(s) and because these payment types are not adjudicated at the point of sale (*i.e.*, they are non-network benefits). In those cases, CMS will pass along the information that the COBC already collects to the beneficiary's Part D plan so that it knows about the non-GHP primary coverage for claims payment and recoveries.

The IEQ cover letter contains the COBC's 1-800 telephone number and suggests that the beneficiary call that number if he/she has any questions or needs help completing the questionnaire. A separate 1-800 telephone number is available for the hearing

impaired. This helps to appropriately direct inquiries to the COBC rather than to the Social Security Administration (SSA) and ensures that expert assistance is readily available should the beneficiary have any questions.

This initiative also affords CMS an opportunity to provide beneficiaries with better information about the decisions they must make when enrolling in Medicare, such as continuing enrollment in an employer plan, declining Medicare Part B, enrolling in Medicare Part D, purchasing Medigap coverage, or enrolling in a Medicare coordinated care plan. This information is vital for potential Part D beneficiaries since they have to opt in to the benefit and since their employer plans may be eligible for the MMA employer subsidy if they do *not* choose Part D.

Since the IEQ process became operational, CMS historically had conducted First Claim Development to secure MSP information for those beneficiaries who do not respond to the IEQ mailing and for those already-enrolled individuals who filed their first Medicare claim. The CMS has since discontinued this development due to its low return on investment.

Medicare beneficiaries 65 and over now have the opportunity to complete the IEQ on the MyMedicare.gov website instead if completing the hardcopy IEQ and mailing it to the COBC. At this time, only the English version of the Beneficiary 65 and over questionnaire is available online and in the future we anticipate the four (4) additional English IEQs and all of the Spanish IEQs will also be available on the MyMedicare.gov website for completion in the near future. The purpose for placing the IEQs online is for beneficiaries to have an alternative of submitting the IEQ that is safe, secure, and can update their beneficiary database within 24-hours from completion. The hardcopy IEQ can take a month after the COBC mails the questionnaire before any MSP information is received and uploads to the beneficiary Medicare database. The MyMedicare.gov website is an improved alternative for beneficiaries to submit the IEQ.

<u>MSP Claims Investigations Process</u>

The COBC performs MSP development in cases where information or the lack thereof indicates that a determination needs to be made about whether payers primary to Medicare exist. These development processes, described below, address: 42 CFR 411.25 (third-party notice), and secondary claims. Information received through these development processes that indicates that there is coverage primary to Medicare Parts A and B is stored in the Common Working File (CWF) and information regarding coverage primary to Part D will be stored in the Medicare Beneficiary Database (MBD). These MSP data may be updated, as necessary, based on additional information received from external parties (*e.g.*, beneficiaries, attorneys, employers, providers, third party payers).

All MSP questionnaires are generated through an electronic print, sort and mail process. Individual beneficiary information is systematically applied to each questionnaire, producing individualized mailings. All responses are returned to the COBC's mailing address shown on the outgoing cover letter, which accompanies the various MSP development questionnaires. In addition, the COBC's toll free number is included on each MSP development letter for any questions that the beneficiary, employer, provider, attorney or any third party payer may have.

The following are the current MSP Claims Investigation activities that the COBC manages on a day-to-day basis.

Processes that Involve the COBC's Electronic Correspondence Referral System (ECRS)

The COBC developed ECRS, an online application tool, used by the FIs, carriers and MACs to transmit information to the COBC. ECRS is also provided to the Part D plans and to CMS' Recovery Audit Contractors. Through these electronic transactions, these Medicare contractors may request the COBC to perform development with beneficiaries, providers, employers, insurers, attorneys and other identified entities or to update an existing MSP record on CWF and/or MBD. After any necessary development, the COBC uses ECRS to alert the requesting/referring plan of any updates it has made to CWF and/or MBD. In each of the following types of development, information that is supplied to a Medicare contractor is forwarded to the COBC via ECRS.

Self-Reporting Development

From time to time, Medicare beneficiaries and other affected parties (*e.g.*, attorneys, family members) "self-report" an MSP situation to their local Medicare contractors; CMS anticipates such reporting will also be made to the Part D plans. If the local Medicare contractor or Part D plan does not receive all pertinent MSP information at the time of the self-reporting, CMS requires the COBC to develop, using a standard set of MSP questions, for the missing MSP data elements.

411.25 Notice Development

The Medicare statute and implementing instructions require that if a third party payer learns that CMS has made a Medicare primary payment for services for which that third party payer either has paid or should have paid on a primary basis, the third party payer must give notice to Medicare contractors. A Medicare contractor receiving this information refers it to the COBC for development.

If, as a result of the COBC's development, an MSP situation is identified, the Medicare contractors must track conditional payments and recover any conditional or

mistaken primary payments from the beneficiary, provider, physician, pharmacy, supplier, or from any third party that has legal responsibility to repay Medicare. The identified claims will be reprocessed as secondary, where applicable. The Medicare contractors are also able to accurately deny any mistaken primary claims received and otherwise process claims after the MSP information is updated.

Secondary Claims Development (SCD)

Sometimes, despite the IEQ and other early activities, an MSP situation goes undetected. In other cases, an MSP situation does not occur until after an individual is already a beneficiary (*e.g.*, a beneficiary suffers injuries from an auto accident and is covered by no-fault insurance). When the provider is aware of a primary payer, however, proper billing can still occur and, under Parts A and B, an FI or carrier receives a claim for secondary payment with another insurer's EOB (explanation of benefits) attached or a Part D plan may receive a secondary claim when the primary payer named on the claim is not in the plan's system. In these cases, the Medicare contractor makes secondary payment, as appropriate, and refers the new information to the COBC for development. When the COBC validates the existence of an MSP situation, it will update CWF and/or MBD with the relevant information, and the Medicare contractor(s) must track conditional payments, perform recoveries, and reprocess claims where applicable.

2. Other Development

Inpatient/Outpatient Provider Development

Any Part A or B provider that bills Medicare for services rendered to beneficiaries must first determine whether or not Medicare is the appropriate primary payer for those services. The providers accomplish this by asking MSP questions of Medicare beneficiaries or their representatives during admissions (inpatient) or encounters (outpatient). The questions were revised based on American Hospital Association suggestions to reduce the paperwork burden on its members. Furthermore, for recurring outpatient services, providers may hold MSP answers for 90 days before being required to ask the questions again. The CMS estimates that this policy results in a 25% reduction in outpatient provider burden from previous PRA packages.

While pharmacies will not ask these questions under the Part D rules due to the time burden it would place on them, this process will include information about whether prescription drugs are covered so that MBD can be appropriately updated for a Part D beneficiary's plan to make proper payment.

Assignment Labs

A hospital reference lab performs tests on specimens that have been referred (sent) to the hospital lab by outside sources. Hospitals must collect MSP information from a beneficiary or his/her representative for hospital reference lab services. The CMS made a policy decision to allow a 90-day application of the MSP questions for these services and required documentation (electronic or hardcopy) of the last (dated) update of the answers. In § 943 of the MMA, Congress prohibited CMS from requiring hospital reference labs to ask MSP questions in situations where CMS does not require independent labs to do so. The CMS estimates that this prohibition amounted to a 50% reduction in laboratory burden from allocations approved in previous PRA packages.

C. Justification

1. Need and Legal Basis

The statutory basis for this information collection is § 1862(b) of the Act. The regulatory basis for this information collection is 42 CFR § 489. The following laws demonstrate the need for MSP collection:

LAW	NEED
§ 1862(b)(5)(D) of the Act	Prior to an individual's applying for benefits under Part A or enrolling in Part B, the Secretary is to mail a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of coverage under such a plan
§ 1860D-2(b)(4)(D)(ii) of the MMA	Allows Part D plans and plan sponsors to ask beneficiaries about what other coverage they may have, and states that material misrepresentation of such coverage by the beneficiary is grounds for termination from Part D
42 CFR 411.25	If a third party payer learns that CMS has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must provide notice to that effect
42 CFR 489.20(f) and (g)	Provider (defined in 489.2(b)) agrees to maintain a system that identifies payers primary to Medicare during the admissions process and to bill other payers primary to Medicare except

	when the primary payer is a liability insurer

The following laws contain MSP amendments or implications:

LAW	EFFECT
Title XVIII of the Act	Medicare is secondary to Workers' Compensation (including Black Lung) Medicare does not pay for services paid for by the Department of Veterans Affairs or other governmental entities
§ 953 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1980	Medicare is secondary to Automobile, Liability, and No-Fault coverage
COBRA 1981 § 2146 as amended	Medicare is secondary for beneficiaries with ESRD in their first 30 months of eligibility.
§ 116 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982	Medicare is secondary for working beneficiaries age 65 to 69 and their spouses age 65 to 69 who are covered by an Employer GHP)
§ 2301 of the Deficit Reduction Act (DEFRA) of 1984	Medicare is secondary for beneficiaries age 65 to 69 regardless of working spouse's age
COBRA 1985 § 9201	Eliminates upper age limit of 69 for "working aged" MSP
COBRA 1986 § 9319	Medicare is secondary for disabled beneficiaries classified as "active individual" and covered by a Large GHP (LGHP)
COBRA 1987	Clarifies that COBRA 1986 applies to governmental entities
COBRA 1989	MSP uniformity provisions and IRS/SSA/CMS Data Match added
COBRA 1993	Changes basis of MSP for disabled beneficiaries from "active individual" to "current employment status"
MMA § 1860D-2(a)(4)	Applies MSP laws to the new Medicare Part D in the same manner as it applies to Part C (Medicare Advantage, formerly Medicare+ Choice)

These laws create a continuing need for information collection so that Medicare can take its proper place as a secondary rather than a primary payer for beneficiaries who fall under one of these provisions.

2. Information Users

The information users are CMS, Medicare contractors, insurers, third party administrators, hospitals, other providers, physicians, pharmacies, and suppliers. The CMS and its Medicare contractors use the information to accurately process and pay Medicare claims and to make necessary recoveries in accordance with § 1862(b) of the Act (42 U.S.C. 1395y(b)). If an active MSP situation is identified and Medicare is inappropriately billed as primary, the claim will be rejected. The hospitals, other providers, physicians, pharmacies, and suppliers use the information collected (and furnished to them on the denial) to properly bill the appropriate primary payer. Completing an MSP questionnaire and making an accurate MSP determination helps hospitals, other providers, physicians, pharmacies, and suppliers to bill correctly the first time, saving the Medicare Program money and affording Medicare beneficiaries an enhanced level of customer service (which, again, is particularly important in Part D due to the real-time adjudication of claims and the complicated nature of its benefit administration). Insurers, underwriters, third party administrators, and self-insured/self-administered employers use the information to ensure compliance with the law by refunding any identified mistaken payments to Medicare.

3. Improved Information Technology (IT)

Since the IEQs and other development activities that are sent to the beneficiaries are for the most part paper forms and filled out manually, that information has not historically lent itself to IT application.

In contrast, most hospitals use automated admission processes, which take less time to input data than the hand-written method. Hospitals maintain this process to comply with 42 CFR 489.20(f).

4. Duplication of Similar Information

The information does not duplicate other information collected by the CMS. These collection activities were created to reduce both burden and redundancy. In the case of hospital re-admissions, MSP information need only be verified against previously gathered MSP information as a means to ensure that there have been no changes in a beneficiary's health insurance coverage which would affect a hospital's decision about primary payers. Verifying this information should take less time than the initial information gathering if the answers to the MSP questions are the same. If MSP information has changed, the time required to make the change(s) should be minimal.

5. Small Business

These requirements are not applicable to small businesses.

6. Collection Frequency

Collecting information on a less frequent basis than is provided for in this submission is expected to create risk to the integrity of the Medicare Trust Fund. CMS believes that the information collection and the frequency of its collection, as described herein, are necessary to comply with the MSP provisions. An MSP provision may affect beneficiaries anytime during entitlement, which directly affects the frequency of information collection activities. And, as noted earlier, First Claim Development has been eliminated as well as all follow-up MSP developments. Any further reduction in information collection activity by CMS will lead to higher losses to the Medicare program. CMS has ensured against duplicate or redundant MSP data collection by placing the responsibility of all MSP collections with one umbrella contractor, the COBC, effective January 8, 2001.

7. Special Circumstances

Five years is generally recognized as the standard for record retention in the industry. However, CMS recommends a record retention period of ten years for MSP questionnaires. The CMS changed from "required ten years" to "recommend ten years" in the last MSP PRA Information Collection submission in July 2005. Absence of the completed MSP questionnaire does not constitute a valid defense against CMS claims for repayment of recovery actions.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice for this information collection request published on March 20, 2009.

CMS published a 30-day notice in July 2005 under the emergency clearance provisions at 5 CFR § 1320.13 and 5 CFR § 1320.8(d)(4).

As to the prescription drug coverage questions that are being added and that were part of the package approved on an emergency basis in July 2005, the MMA required CMS to conduct consultation sessions with relevant parties in the pharmacy and insurance industries, and CMS has developed its Part D MSP collection questions as a result of those sessions. Industry input was key in deciding what information needed to be collected and who should have access to such information.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

The information collected is protected under the Privacy Act.

11. Sensitive Questions

There are no questions of a sensitive nature associated with these requirements.

12. Burden Estimate (hours and wages)

42 CFR 489.20(f) & 42 CFR 489.20(g) - Third party identification.

RECORDKEEPING

5 CFR 1320.3(b)(2): (Controlling Paperwork Burdens On The Public) states: "The time, effort, and financial resources necessary to comply with a collection of information that would be incurred by persons in the normal course of their activities (*e.g.*, in compiling and maintaining business records) will be excluded from the 'burden' if the agency demonstrates that the reporting, recordkeeping, or disclosure activities needed to comply are usual and customary."

Identification and collection of information concerning proper payers during the admission process are common business practices in the health care field. In addition, many hospitals have reaped benefits and will continue to realize significant benefits by identifying primary payers during the admission process. This relates to the fact that a private payer's rate of payment is normally based on a percentage of charges; whereas, for Medicare patients, the hospital receives the Medicare payment, which is generally an amount paid under the prospective payment system.

The annual burden is estimated below. Because the questions about prescription drugs have not yet been used, the estimate for this package was created by taking calendar year 2004 numbers and projecting on top of them the time that is expected to be spent answering the prescription drug questions. The number of responses and estimated incidence of MSP situations were not altered to account for Part D because no more people will have to answer questions than did before, but rather a subset of people who answer yes to having MSP in general will have to fill in the drug questions as not all health care coverage includes drugs.

Burden Due to COBC Development

IEQ - SSA § 1862(b)(5)(D)[1]

Number	2,528,000
Response Time	18 minutes
Paperwork Hours	758,400 hours

411.25 Notices

Number	50,232
Response Time	18 minutes
Paperwork Hours	15,070 hours

Self Reporting Development

Number	250,002
Response Time	18 minutes
Paperwork Hours	75,001 hours

Secondary Claim Development

Number	145,000
Response Time	18 minutes
Paperwork Hours	43,500 hours

Total Paperwork Hours A**ttributable to COB Development**

Type of Development	**Paperwork Hours**
IEQ	758,400
411.25 Notices	15,070
Self-Reporting Development	75,001
Secondary Claims Development	43,500
Total	**891,971**

Burden Due to Other Collections

The MSP questionnaire listed in the MSP manual has 6 parts with a total of 23 questions. There will be an addition of 3 drug-coverage-related questions that only need to be answered if the beneficiary does have an MSP situation and some type of coverage that should pay primary. However, because a beneficiary is instructed to answer only applicable questions, he or she will at most answer 15 questions (including the drug questions). Of those 15 questions, 10 are the same questions that hospitals ask non-Medicare patients for coordination purposes. Therefore, since Medicare requires only 5 additional questions to be completed for MSP development, Medicare is responsible for only those 5 additional questions, or 1/3 of the total burden. In addition, Medicare's portion of the total burden must be decreased by an estimated 25% for the

[1] Note: These estimates are not being reduced even though follow-up developments are no longer being sent, since such reductions are offset by the increase in the number of beneficiaries and the number of claims filed annually.

90-day policy for recurring outpatient services and by an estimated 50% for the recently implemented policy for reference lab services (assuming that half of all assigned lab claims are reference lab claims).

The following calculations represent CMS's best estimate of its share of the paperwork burden regarding this collection On average, MSP affects about 6% of beneficiaries; the positive/negative response allocations below are calculated using that average.

Inpatient Claims

Beneficiary Responses	15,246,577
Negative responses (No MSP)	14,331,782
Positive responses	914,795
Response Time (Burden)	
Negative (1 minute)	238,863 hours
Positive (10 minutes)	152,466 hours
Total	391,329 hours
Portion attributable to CMS (1/3 total)	**130,313 hours**

Outpatient Claims

Beneficiary Responses	108,681,146
Negative responses	102,160,277
Positive Responses	6,520,869
Response Time (Burden)	
Negative (1 minute)	1,702,671 hours
Positive (10 minutes)	1,086,812 hours
Total	2,789,483 hours
Portion attributable to CMS	
Base number (1/3 total)	928,898 hours
With 25% reduction (90-day policy)	**696,673 hours**

Assigned Lab Claims

Beneficiary Responses	16,169,260
Negative responses	15,199,104
Positive Responses	970,156
Response Time (Burden)	
Negative	253,318 hours
Positive	161,693 hours
Total	415,011 hours
Portion attributable to CMS	
Base number (1/3 total)	138,199 hours
With 50% reduction (MMA § 943)	**69,100 hours**

Total Burden

Type of Collection	Annual Responses	Paperwork Hours
COBC Development	2,973,234	891,971
Inpatient	15,246,577	130,313
Outpatient	108,681,146	696,673
Lab	16,169,260	69,100
Total	**143,070,217**	**1,788,057**

Dollar Burden

Total Paperwork Hours x $12.00/hour = 1,788,057 x $12 = $21,456,684

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

42 CFR 489.20(f) - Third party identification.

This information collection process falls within the regular operating budget of the FIs. Therefore, there is no additional cost to the Federal government.

IEQ - SSA § 1862(b)(5)(D)

The COBC sends questionnaires to all new Medicare enrollees to identify those who have other insurance coverage that is primary to Medicare. Any responses that are incomplete or inconsistent are developed by the COBC. All Parts A and B data received from the completed questionnaires are transmitted to CWF, and all Part D data received are sent to MBD. The projected cost of this activity for FY 2009, which is part of the COBC's contract, is $5,837,439

15. Program Changes/Changes in Burden

The increase in the total annual burden and the number of responses is due to an increase in the total number beneficiaries and claims filed annually.

16. Publication and Tabulation

There are no plans to publish or tabulate the information collected for statistical use.

17. Expiration Date

We request that this requirement be excepted. Due to the ongoing nature of this collection, we do not believe a reference to an expiration date is in the best interest of this collection. The expiration date will not be displayed on each MSP development letter since much of the MSP data collection process is automated. The omission of the expiration date will obviate the necessity to reprogram our systems each time OMB extends approval for MSP data collection.

18. Certification Statement

There are no exceptions to the certification statement.

D. Statistical Methods

This collection of information does not employ statistical methods.