Supporting Statement for Paperwork Reduction Act Submissions
Provider-Preventable Conditions under 42 CFR 438.6 and 447.26 and Title 2702 Non-Payment Preprint (Attachment 4.19)
CMS-10364, OMB 0938-NEW

A. Background

These collections are required because they will allow States to know when provider payment penalty is warranted as a result of a provider preventable condition (PPC). The collection will also allow CMS to ensure that States are not making payments to providers for PPCs.

In CMS-2400-F, "Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions" (published June 6, 2011), section 438.6(f)(2) will require States which provide medical assistance using a managed care delivery system to modify their managed care contracts to reflect the PPCs payment adjustment policies as applied through these regulations.

Section 447.26(c)(1) will require States to submit SPAs for CMS approval that would reduce payments to providers by amounts related to PPCs. The burden associated with this requirement will be the time and effort necessary for a State to submit its SPA and an associated pre-print.

Section 447.26(c)(2) will also require States to implement provider reporting requirements to ensure that PPCs are identified in claims for Medicaid payment.

B. Justification

1 . Need and Legal Basis

This information is will be used to ensure that State Medicaid agencies are reimbursing providers for services within the guidelines of Federal Statute, regulations, and related policy. The Agency uses this information as the basic reimbursement contract with States. This information also is used as an analysis tool in determining whether reimbursement amounts are reflective of actual service levels covered under the Medicaid plans.

2. Information Users

This information will be used by States and the Centers for Medicare and Medicaid Services in determining the appropriate payment for services is being made under a Medicaid State plan. This particular information is not currently collected through this vehicle. However, the agency typically uses this type of information as assurance that the State is reimbursing providers in adherence with Federal Statute and within required limits.

3. Use of Information Technology

This type of collection is currently performed through the use of electronic systems shared between the States and providers and the States and CMS. Respondents may have to provide signature when transmitting data, however this type of signature capability would already exist in situations where a signature is necessary.

4. Duplication of Efforts

This information is not currently required by Medicaid.

5. Small Businesses

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

6. Less Frequent Collection

States are not required to report this information separately or at any intervals not consistent with their existing submission. Providers will report this information to States when instances occur, we cannot decrease the collection beyond this point because the collection is directly related to paid claims.

7. Special Circumstances

There are no special circumstances or impediments.

8. Federal Register/Outside Consultation

The proposed rule published on February 17, 2011 (76 FR 9283). No PRA-related comments were received.

9. Payments/Gifts to Respondents

No decision to provide any payment or gift to respondents has been made.

10. Confidentiality

There is no separate confidentiality requirement for this collection.

11. Sensitive Questions

There are no questions of a sensitive nature requested as part of this collection.

12. Burden Estimates (Hours & Wages)

Section 438.6(f)(2) will require States which provide medical assistance using a managed care delivery system to modify their managed care contracts to reflect the PPCs payment adjustment policies as applied through these regulations. The burden associated with this requirement is the time and effort necessary for a State to amend its managed care contracts to reflect these policies. We estimated that 48 States will be required to comply with this requirement. We also estimated that it will take 8 hours for each State to revise its contracts to comply with this requirement and submit the amended contract to CMS for review and approval. The total estimated annual burden associated with this requirement is 384 hours at a cost of $20.67 per hour per State.

Section 447.26(c)(1) will require States to submit SPAs for CMS approval that would reduce payments to providers by amounts related to PPCs. The burden associated with this requirement will be the time and effort necessary for a State to submit its SPA and the associated pre-print. We estimated that 55 States, The District of Columbia, and Territories will be required to comply with this requirement. We further estimated that it will take each State 7 hours to submit the aforementioned documentation to CMS. The total estimated burden associated with this requirement would be 385 hours at a cost of $20.67 per hour per State.
We estimated that it will take each State 7 hours because we intend to issue a template to States to simplify the process of making the related amendment to the Medicaid State plan.

Section 447.26(c)(2) will also require States to implement provider reporting requirements to ensure that PPCs are identified in claims for Medicaid payment. The burden associated with this requirement is the time and effort necessary to develop and implement provider reporting requirements that are effective with the provisions of this regulation. We estimated that 55 States, The District of Columbia, and Territories will be required to comply with this requirement. Similarly, we estimated that it will take 24 hours for each State to develop and implement the provider reporting requirements as specified above. The total estimated burden associated with this requirement will be 1320 hours at a cost of $20.67 per hour per State. We believe that this estimate is reasonable because we are requiring that States have providers use their existing claims processes to report identified events.

Table 1 - Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control No.	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($)	Total Labor Cost of Reporting ($)	Total Capital / Maintenance Costs ($)	Total Cost ($)
438.6(f)(2)	0938-NEW	48	48	8	384	20.67	7,937.28	0	7,937.28
447.26(c)(1) Preprint	0938-NEW	55	55	7	385	20.67	7957.95	0	7,957.95

447.26(c)(2)	0938-NEW	55	55	24	1,320	20.67	27,284.4	0	27,284.40
TOTAL		158	158	39	2089	----	----	0	43,179.63

The estimated annual burden associated with the requirements under 438.6(f)(2), 447.26(c)(1), 447.26(c)(2), and preprint is 2,089 hours (total) at a cost of $43,179.63 (total) or $806.13 (per State).

13. Capital Costs

    This collection does not require any additional capital related costs. States will need incorporate any claims systems changes consistent with how they are amended for other updates.

14. Cost to Federal Government

    This collection does not represent any additional costs to the Federal Government.

15. Changes to Burden

    This is a new collection.

16. Publication/Tabulation Dates

    The collection's results will not be published outside of the States' existing formats for sharing State Medicaid actions.

17. Expiration Date

    CMS requests an expiration date three years from the date of original OMB approval.

18. Certification Statement

    There are no exceptions to the certification statement.

C. Collections of Information Employing Statistical Methods

The use of statistical methods does not apply to this ICR.