

Application to Use Burden/Hours from Generic PRA Clearance:
Medicaid and CHIP State Plan, Waiver, and Program Submissions
(CMS-10398, OMB 0938-1148)

**Information Collection #32 Provider-Preventable Conditions under 42 CFR 438.6 and
447.26 and Title 2702 Non-Payment Preprint (Attachment 4.19)**
(Formerly CMS-10364, OCN 0938-1136)

June 27, 2014

Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services (CMS)

Please note that the template is currently approved under 0938-1136 (CMS-10364) which is set to expire on July 31, 2014. We are seeking to roll CMS-10364 under this generic (CMS-10398) package and will formally discontinue CMS-10364 upon approval of this rollover.

A. Background

The Centers for Medicare & Medicaid Services (CMS) works in partnership with States to implement both Medicaid and the Children's Health Insurance Programs (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to elect new options available as a result of the Affordable Care Act or to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of health reform, including program waivers and demonstrations, and other technical assistance initiatives.

B. Description of Information Collection

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) requires States that 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 438.6(f)(2) requires impacted states to modify their managed care contracts to include PPC payment adjustment policies outlined in CMS-2400-F.

Section 447.26(c)(1) requires States to submit SPAs for CMS approval that would reduce payments to providers by amounts related to PPCs.

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

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

Program/Burden Changes

At this time, all states have submitted SPAs containing the subject pre-print and we do not anticipate any amendments during the next 3 years. However, since this is an active preprint and

the respondent number (50) exceeds the PRA trigger (9), we are estimating 2 annual responses to keep the preprint active. While the number of respondents has been revised, the burden per response remains unchanged. These figures will be adjusted if/when necessary.

Additionally, this package adds instructions for completing the template.

Burden Estimates

Section 438.6(f)(2) requires impacted states to modify their managed care contracts to include PPC payment adjustment policies outlined in CMS-2400-F. The burden associated with this action consists of 8 hours per state which is the amount of time it will take for a state to update its existing managed care contracts to reflect PPC requirements.

Section 447.26(c)(1) requires States to submit SPAs for CMS approval that would reduce payments to providers by amounts related to PPCs. The burden associated with this requirement is 7 hours per state which includes the time and effort necessary for a State to submit its SPA and an associated pre-print.

Section 447.26(c)(2) requires States to implement provider reporting requirements to ensure that PPCs are identified in claims for Medicaid payment. The burden associated with this action is 24 hours per state which includes the time and effort associated with a states' ability to create the appropriate claim edits by which PPC are identified and can be reported.

The total burden ceiling of the generic ICR is 86,240 hours, and CMS previously requested to use 50,094 hours, leaving our burden ceiling at 36,146 hours. The information requested in this collection is readily available to states, and CMS estimates that each state will complete the collection of data and submission to CMS within 39 hours. While there is a potential universe of 55 respondents, we do not anticipate any amendments during the next 3 years and are estimating 2 annual responses since this an active preprint. Consequently, the total burden deducted from the total for this request is 78 hours (2 responses (aggregate)/yr x 39 hr/response).

E. Timeline

The template is currently approved under 0938-1136 (CMS-10364) which is set to expire on July 31, 2014. We are seeking to roll CMS-10364 under this generic (CMS-10398) package and will formally discontinue CMS-10364 upon approval of this rollover.

The following attachments are provided for this information collection:

- Provider-Preventable Conditions Pre Print
- PPC Final Instructions (pdf)