Healthcare Fraud Prevention Partnership (HFPP): Data Sharing and Information Exchange
(CMS-10501, OMB 0938-1251)

Generic Information Collection (GenIC) #1: Generalized Claims Data Call Submission

Center for Program Integrity (CPI)
Centers for Medicare & Medicaid Services (CMS)

A. Background

Section 1128C(a)(2) of the Social Security Act (42 U.S.C. § 1320a-7c(a)(2)) authorizes the Secretary and the Attorney General to consult, and arrange for the sharing of data with representatives of health plans for purposes of establishing a Fraud and Abuse Control Program as specified in Section 1128(C)(a)(1) of the Social Security Act. The result of this authority has been the establishment of the Healthcare Fraud Prevention Partnership (HFPP). The HFPP was officially established by a Charter in fall 2012 and signed by HHS Secretary Sibelius and US Attorney General Holder.

B. Description of Information Collection

The HFPP is a joint initiative established by the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) to detect and prevent healthcare fraud, waste, and abuse. A central goal of the HFPP is to identify optimal ways to coordinate nationwide sharing of healthcare claims information, including the aggregation of claims and payment information from large public healthcare programs and private insurers. Through data and information-sharing and the application of analytic capabilities by the public and private sectors, the HFPP supports a data-driven model for the prediction, identification, and prevention of aberrant activity. A central goal of the HFPP is to identify the optimal way to coordinate nationwide sharing of health care claims information, including aggregating claims and payment information from large public healthcare programs and private insurance payers. In addition to sharing data and information, the HFPP is focused on advancing analytics, training, outreach, education to support anti-fraud efforts and achieving its objectives, primarily through goal-oriented, well-designed fraud studies.

C. Deviations from Generic Request

None. There is no deviation from the initial package to this collection.

D. Burden Hour Deduction

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CMS estimates the burden on its new monthly format. Participating entities will acquire an average annual burden of 40 hours of partner engagement and support based on an initial 1 year data pull followed by monthly submissions. The data pull will take 120 hours for year 1 (120 hours for initial data pull) with no initial data pull for years 2 and 3. The 120 hours averaged over a 3-year OMB approval period is 40 hours per year. The burden hours for monthly submissions which will total approximately 120 hours in Years 2 and 3. This includes burden hours necessary for data extract, quality assurance, definition resolution, and information/data transmission over the 3 year period.

<u>Initial Data Pull (Year 1)</u>
Total 3-year Burden = 20 entities x 6 (hours/entity) = 120 hours
Annual Burden = 120 hours ÷ 3 = 40 hours

<u>Monthly Submissions (Years 2 and 3)</u>

Total 3-year Burden = 20 entities x 6 (hours/entity) = 120 hours
Annual Burden = 120 hours ÷ 3 = 40 hours

Total Annual Burden
Initial Data Pull + Monthly Submissions = 40 hours + 40 hours = 80 hours

E. Timeline

CMS hopes to begin this collection in December 2017.

The following attachments are provided for this information collection:

- Data submission Instructions
- Generalized Claims Data Call Submission