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 #5: Medicaid Payment Suspensions

December 2014

Center for Medicaid and CHIP Services (CMCS)

Centers for Medicare & Medicaid Services (CMS)

A. Background

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children's Health Insurance Program (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

CMS is requesting to collect regarding payment suspensions States have imposed against providers during the relevant reporting period. Under section 6402(h)(2) of the Affordable Care Act, States may not receive Federal matching funds when they fail to suspend payment to providers for which there is a pending investigation of a credible allegation of fraud against such providers, unless the State determines there is good cause to not suspend payments. The Final Rule implementing section 6402(h)(2) of the Affordable Care Act requires States to annually report to CMS information regarding payment suspensions they have imposed against providers during the relevant reporting period. CMS plans to collect this data from States via a portal on the Medicaid.gov website.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 86,240 hours, and CMS previously requested to use 6,720 hours, leaving our burden ceiling at 79,520 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 20 hours. There is a potential universe of 56 respondents, so the total burden deducted from the total for this request is 1,120 hours.

E. Timeline

Not applicable. This is an extension (without change) of a currently approved GenIC.

Attachments

The following attachments are provided for this information collection:

Attachment A – Payment Suspension Screen Shots