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 #28 MMIS APD Template NCCI Coding Initiative

Formerly OCN 0938-1123 (CMS-10358)

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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. States and the Centers for Medicare & Medicaid Services (CMS) share responsibility for operating Medicaid programs consistent with title XIX of the Social Security Act and its implementing regulations. Together, the federal and state governments share accountability for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers

B. Description of Information Collection

CMS has developed a Medicaid Management Information System (MMIS) Advance Planning Document (APD) template, specifically to support the October 1, 2010, mandate of the National Correct Coding Initiative (NCCI) in Medicaid. The template follows section 1903(r) of the Social Security Act (the Act). The template has been designed for the collection of information for two purposes:

1. To collect key information required for states to request 90 percent federal financial participation (FFP) for the design, development, and installation, and 75 percent FFP for the maintenance and operations, of MMISs, in accordance with section 1903(a)(3) of the Act.

2. To collect and report key information per section 1903(r)(4)(B) of the Act, as added by section 6507 of the Affordable Care Act (ACA), that includes analysis supporting the identification and use of the NCCI methodologies for Medicaid. States are required to report to CMS quarterly estimates of savings in Medicaid program costs due to use of the Medicaid NCCI methodologies in processing and paying Medicaid claims.

Section 6507 of the Patient Protection and Affordable Care Act amends section 1903(r) of the Social Security Act (the Act). As amended, it required CMS to take three specific actions by September 1, 2010. First, CMS must notify states of NCCI methodologies that are "compatible" with claims filed with Medicaid to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. Second, CMS must notify states of the NCCI methodologies (or any successor initiative) to promote correct coding and to control improper coding leading to inappropriate payment that should be incorporated for claims filed with Medicaid, for which no national correct coding methodology has been established for Medicare. Third, CMS must inform states as to how they must incorporate these methodologies for claims filed under Medicaid. CMS was required submit a report to Congress by March 1,

2011, that included the September 1, 2010, notice to states and an analysis supporting these methodologies. Section 1903(r)(1)(B)(iv), as amended, requires that states incorporate compatible methodologies of the NCCI administered by the Secretary and such other methodologies as the Secretary identifies, effective for Medicaid claims filed on or after October 1, 2010.

This collection is mandatory under the Patient Protection and Affordable Care Act (Affordable Care Act). The result of collecting and studying this data provides cost and savings results by states and in the aggregate will provide important information on the effectiveness of the National Correct Coding Initiative edits in the Medicaid program

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 45,028 hours, leaving our burden ceiling at 41,212 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 3 hours at 5 responses/yr (as needed). There is a potential universe of 56 respondents, so the total burden deducted from the total for this request is 840 hours.

E. Timeline

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

Attachments
The following attachment is provided for this information collection:

- Advance Planning Document (APD) Template