Supporting Statement – Part A
CMS-10406/OMB Control Number 0938-1192

Supporting Statement For Paperwork Reduction Act Submissions

A. Background

This request is for OMB approval for a set of instruments to be used in a probable fraud measurement pilot by the Centers for Medicare & Medicaid Services (CMS). The goal of this pilot is to develop the first nationally representative estimate of the extent of probable fraud in payments for home health care services in the fee-for-service Medicare program. The estimate will help senior leaders within the Department of Health and Human Services (DHS), Congress, and the White House make more informed decisions related to combating fraud, and it will provide a baseline probable fraud estimate for CMS to track probable fraud over time. The instruments will be used to conduct interviews with Medicare beneficiaries, home health agency (HHA) staff, and referring providers. This is the first submission related to these instruments, which were developed for use in this pilot.

Fraud in Medicare

Health care fraud is a source of considerable concern in the Medicare program, but a statistically valid estimate of the rate of fraud in Medicare does not currently exist. Documenting the baseline amount of fraud in Medicare is of critical importance as it allows officials to evaluate the success of ongoing fraud prevention activities. These data will improve CMS's ability to evaluate the extent to which anti-fraud activities prevent or reduce fraudulent payments in Medicare.

Probable Fraud Measurement Pilot

CMS, in collaboration with the Office of the Assistant Secretary for Planning and Evaluation (ASPE), developed a pilot to estimate the percentage of national Medicare fee-for-service payments in home health made based on claims that are probable fraud. CMS has designated revalidating home health agencies as having a "moderate categorical risk" of fraud, waste or abuse, while newly enrolling home health agencies are one of two service areas that CMS has designated as having a "high categorical risk" of fraud, waste, and abuse.[1]

This pilot focuses on probable fraud rather than "actual fraud" because determining fraud requires legal proof of intent. The False Claims Act, which applies to most payments made by the federal government, provides civil and criminal remedies for a provider or supplier who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval."[2] The

[1] The other area named by CMS is newly enrolling durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. 42 C.F.R. § 424.518.
[2] False Claims Act of 1863, 31 U.S.C. § 3729(a)(1)(A) (2011).

requirement of establishing intent must be met by a court of law and cannot be met through a data collection effort alone. In addition, it would be infeasible to wait for the resolution of individual legal proceedings to establish intent in the context of a large-scale data collection, particularly when the goal is to produce a timely estimate of fraud. Although intent cannot be proven based on an examination of secondary data sources, an estimate of the extent of probable fraud is possible.

This pilot defines a claim as "probable fraud" if a member of a Review Panel composed of experienced health care fraud investigators determines that a review of the information surrounding the claim uncovered sufficient evidence to warrant a referral to law enforcement for further investigation of the provider's conduct. The Review Panel will consult with health care analysts, clinicians, and policy experts to aid the Review Panel members in their decision-making. While law enforcement agencies may decline to investigate claims below a certain dollar amount, the Review Panel will not take into account such constraints when evaluating each case. This definition establishes a reasonable bar for the determination of "probable fraud," given the gravity of law enforcement involvement, and also initiates the formal process for a determination of actual fraud, which only law enforcement can make.

The Review Panel will make probable fraud determinations for a random sample of home health claims that are selected for this pilot. To make these determinations, the Review Panel will rely on several sources of evidence related to each sampled claim. One of the most important sources is the set of completed interview instruments for the sampled beneficiary, home health agency, and referring provider listed on the claim; these instruments are described in greater detail below.

In addition to the completed interview instruments, the Review Panel will rely on collected documentation related to the sampled claim and on observations made by the interviewers during their visit with their interview subjects. The Review Panel also considers a summary of the service history of the HHA, the referring provider, and the beneficiary, and information about whether the sampled HHA or referring provider is the subject of an active investigation by law enforcement agencies.

The pilot will use Review Panel findings to calculate a national estimate of probable fraud in Medicare fee-for-service home health services. Weights derived from the sampling procedure will be used to translate the results from the sample into results that represent the population of home health claims. The pilot will estimate the percentage of total payments that are associated with probable fraud and the percentage of all claims that are associated with probable fraud.

Interview Instruments Overview

The interview instruments under consideration in the current PRA submission are designed to answer four questions related to the claims sampled for this pilot:

- Was the service indicated on the claim provided to the beneficiary?
- Was the service medically necessary?

- Was the beneficiary eligible to receive the service?
- Is there evidence of intent to defraud Medicare on the part of the HHA and/or the referring provider?

This pilot will use three different instruments to conduct interviews with the three primary parties identified on the home health claim: the beneficiary[3], the HHA, and the referring provider. CMS will send trained interviewers with knowledge of the Medicare program and experience in investigating fraud to conduct unannounced interviews with the beneficiaries and HHAs listed on the sampled claim. The pilot uses unannounced interviews to reduce the opportunity for fraudulent providers to alter or fabricate records or to coach the beneficiary in answering questions. CMS will conduct scheduled interviews with the referring providers listed on the sampled claims; half of these interviews will be conducted in person, and half will be conducted by phone.

CMS developed each of the three instruments for this pilot based on extensive consultation with experts in Medicare home health benefit policy and fraud investigation. The instruments contain questions for the interview subjects as well as requests to collect documentation related to the services provided on the sampled claim. The collected documentation includes provider operational documentation and beneficiary medical records. The interviews will be conducted by personnel with experience interviewing Medicare beneficiaries and providers, and the interviewers will be trained to follow a set of interview protocols developed for this pilot.

Future Activities Following Completion of Pilot

CMS plans for activities following completion of the pilot are conditional on two factors: i) the results of the pilot and ii) lessons learned about the logistics of pilot implementation.

CMS will utilize the results of the pilot to inform future fraud prevention and detection activities. CMS will compare the baseline rate probable fraud rate calculated during the pilot to future probable fraud estimates to track the change in the level of probable fraud over time. Additionally, while the pilot does not have sufficient sample size to calculate statistically significant differences across regions, CMS will use pilot data as an informal information source about the regional distribution of fraud. CMS will also utilize pilot data to identify new fraud schemes and incorporate this knowledge into future fraud prevention and detection efforts. Finally, CMS will use evidence of fraudulent activity uncovered during the investigation to either open investigations or make referrals to law enforcement.

Moreover, CMS will utilize the lessons learned during implementation of the pilot to inform future efforts at fraud estimation. Based on the experience of conducting the pilot, CMS may choose to move forward with additional implementations of the pilot focused on probable fraud in durable medical equipment (DME) and other service areas. Additionally, CMS may use lessons learned

3 In cases when the beneficiary is unable to respond due to cognitive impairment, death, or another factor, the interviewer will seek out a proxy, such as a family member or other caregiver, to complete the interview.

during the pilot to revise the pilot design to improve its effectiveness.

CMS will evaluate the pilot according to several criteria to decide whether to adopt the pilot as an ongoing probable fraud measurement strategy going forward. First, CMS will consider feasibility, determining whether the data collection procedures were successful in generating a high response rate and in collecting the information necessary to aid the Review Panel in making a probable fraud determination. Second, CMS will review the pilot's precision, tracking the share of probable fraud cases over time that result in a legal determination of actual fraud and/or action by law enforcement or Medicare contractors against the provider in question. Finally, CMS will assess the pilot's replicability, testing whether future implementations produce consistent estimates of probable fraud.

B. Justification

1. Need and Legal Basis

The Probable Fraud Measurement Pilot aims to establish an estimate of the amount of probable fraud in the Medicare fee-for-service home health benefit. CMS will use this estimate as a baseline to measure the relative effectiveness of initiatives or programs intended to prevent fraud.

The statutory authority for the pilot is section 1893 of the Social Security Act ("the Act"), 42 U.S.C. 1395ddd, entitled, "Medicare Integrity Program." In pertinent part, this section of the Act requires the Secretary of the Department of Health and Human Services (HHS) to promote the integrity of the Medicare program by entering into contracts with private organizations, or otherwise, to carry out the following activities:

> Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).[4]

2. Information Users

The Review Panel selected for the pilot will use the information collected via the interview instruments, along with the collected supporting documentation and interviewer observations, to aid in determining whether each of the sampled claims represents probable fraud. The personnel conducting the interviews, the Zone Program Integrity Contractors (ZPICs), may use evidence of

[4] Section 1893(b)(1) of the Social Security Act, 42 U.S.C. 1395ddd(b)(1).

fraudulent activity obtained during data collection to initiate an investigation. HHS staff will subsequently use information obtained from the pilot to improve fraud prevention and detection efforts and to design future fraud measurement efforts in other Medicare service areas.

3. Use of Information Technology

The administration of the interview instruments to Medicare beneficiaries, HHAs, and referring providers cannot be made entirely electronic. Unannounced interviews and in-person observation are essential to the success of the pilot. For these reasons it would not be feasible to conduct interviews via an online survey or other electronic administration method to minimize burden. Depending on resource availability, some interviewers may use electronic Adobe Acrobat PDF fillable versions of the instruments stored on laptops or other devices to record responses, and others may use paper versions.

Interviewer observations and on-site visits are essential to the success of the pilot. Observations recorded by the interviewer during the beneficiary visit provide valuable information to be used by the Review Panel in making their determination of probable fraud. The interviewer notes will include but not be limited to: the beneficiary's apparent cognitive abilities, mobility, and other conditions that would inform the beneficiary's eligibility for services.

Interviews with HHAs must be conducted in person in order to limit the opportunity for the provider to alter or fabricate medical records and other documentation. Interviewer observations also provide important information for the Review Panel. During the visit, the interviewer will assess whether the HHA has an appropriate record-keeping system and reasonable staffing levels. Additionally, the interviewer will identify evidence of document alteration, duplication, or fabrication, indicators of an irregular relationship between the HHA and either the referring provider or the beneficiary, as well as other potential indicators of intent to defraud.

For referring provider interviews, CMS believes that interviewer observations could aid the Review Panel in making a probable fraud determination, but the marginal benefit of conducting these interviews in person compared to over the phone is unknown. Since half of the sampled claims will include an on-site visit to the referring provider and half will include administration of the interview instrument by phone with documentation collected by mail, CMS will be able to use the pilot to determine the marginal benefit of conducting these interviews in person, which may impact future pilots. If the benefit is low, CMS may determine that future fraud measurement efforts may include interviews of referring providers by phone or by other means.

For all of these reasons, the information collection cannot be completed electronically. This would remain the case even if CMS had the capability of accepting electronic signatures.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be

obtained from any other source.

5. Small Businesses

This pilot requires collection of financial and operational documentation from medical providers that may be designated as small businesses. CMS has estimated that 98 percent of HHAs are small businesses.[5] To mitigate the burden on small businesses, documentation for all HHAs will be collected during a single unannounced on-site visit. The interviewer will scan or copy the required documentation, which will reduce the burden on the HHA. Similarly, for half of the sampled claims, documentation will also be collected from the referring provider via on-site visits. Unlike site visits to HHAs, visits to referring providers may be scheduled in advance for a time that is convenient to the provider. For the other half of the sample, documentation must be collected via mail, meaning the referring provider will be responsible for assembling and mailing all required documentation either by paper or electronic media (i.e., CD or DVD). This is necessary to allow researchers to determine the relative effectiveness of in-person versus telephone interviews for referring providers for the purpose of measuring probable fraud. The pilot reduces the burden on both HHAs and referring providers by requesting documentation related only to one recent claim.

This pilot does not burden HHAs or referring providers with any additional documentation maintenance requirements beyond what these providers already observe as required by Medicare regulations and/or in accordance with accepted HHA or provider record-keeping practices. The Code of Federal Regulations (42 CFR 424.516(f)) requires both HHAs and referring providers to maintain documentation related to the provision of or referral to home health services for seven years and to make such documentation available to CMS or a Medicare contractor upon request. Section 1833(e) of the Social Security Act states that providers of health services must furnish "information as may be necessary in order to determine the amounts due" to receive payment for services provided to Medicare beneficiaries.

6. Less Frequent Collection

CMS may repeat this information collection in future years based on the success of the pilot, but few beneficiaries, HHAs, or referring providers in the pilot sample are likely to face an added burden as a result of any future information collection activities because the sample size is small relative to the population of beneficiaries, HHAs, and referring providers. The probability that any beneficiary, HHA, or referring provider in the pilot sample will be selected for an interview in future years is well under 0.01 percent.

The information provided to CMS via this information collection is necessary to establish an estimate of the amount of probable fraud in fee-for-service home health payments in the Medicare program. Lack of this information hinders CMS's ability to evaluate the relative effectiveness of programs and initiatives intended to prevent home health Medicare fraud. In addition, if the

[5] Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2012, 76 FR 68526, 68601 (Nov. 4, 2011).

information collection does not take place CMS will be unable to complete the pilot and to use that information to inform the design and implementation of potential future initiatives to estimate the level of fraud in other Medicare services.

7. Special Circumstances

There are no special circumstances associated with this collection.

8. Federal Register/Outside Consultation

A Technical Expert Panel (TEP) was convened on August 10, 2011 to provide feedback on sampling methods, instrument development, interview protocol design, and the general application of survey methods to health care services and fraud measurement. The TEP consisted of seven panelists external to CMS with expertise in large government health care surveys, statistical properties of survey sampling methods, instrument development and protocol design, and fraud investigation and measurement. During the TEP, these panelists were given the opportunity to discuss and offer feedback on the details of the Probable Fraud Measurement Pilot design.

In addition, personnel from the HHS OIG and contractors with expertise in Medicare home health benefit policy and fraud investigation were consulted regarding interview protocols and the content of the instruments used to interview HHAs, referring providers, and beneficiaries. These experts confirmed that the instruments collect information necessary to make a determination on whether the service billed corresponds to the service provided, whether that service was medically necessary, and whether the beneficiary was eligible to receive the service.

CMS did not consult representatives of those from whom the information is to be obtained. This pilot requires collection of documentation from HHAs and beneficiaries, neither of whom will receive advance notice of the collection. Unannounced visits and interviews are crucial to this pilot to reduce the opportunity for fraudulent providers to alter or fabricate records or to coach the beneficiary in answering questions.

A 60-day notice published in the Federal Register on February 5, 2016 (81 FR 6275). CMS received two comments. A 30-day notice will publish in the Federal Register on _____.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

CMS will comply with all Privacy Act, Freedom of Information laws and regulations that apply to

this collection. Privileged or confidential commercial or financial information is protected from public disclosure by Federal law 5 U.S.C. 522(b)(4) and Executive Order 12600.

The confidentiality of beneficiaries' medical information will be protected in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

11. Sensitive Questions

There are no sensitive questions.

12a. Burden Estimates (Hours & Wages)

For each of the 2000 claims in the sample, investigators will conduct interviews with the beneficiary, staff from the HHA, and the referring provider. Estimating the total burden in hours and wages for this information collection requires (i) estimating the burden for each of these three separate groups of interview subjects, and (ii) summing each of these estimates to produce a total burden estimate. Because the interview instruments have only been used in practice for the nine claims in the pilot field test (described in Statement B), there is uncertainty in the estimates of the duration of each interview. To account for this uncertainty, each of the hour and wage burden estimates below includes a lower and upper bound as well as an average of the two. The wage burden estimates rely on data from the Bureau of Labor Statistics (BLS) May 2014 National Industry-Specific Occupational Employment and Wage Estimates.

Beneficiary Interview Hour and Wage Burden

Based on the results of the pilot field test as well as interviews with subject matter experts (SMEs), interviews with beneficiaries are expected to take from 0.25 to 1 hour, with an average duration of 0.625 hours.[6] To calculate the estimated total hour burden for all beneficiaries in the sample the individual hour burden estimates are multiplied by 2000. The estimated hour burden per beneficiary as well as the estimated hour burden for the entire sample of beneficiaries is presented in Table 1.

Table 1: Beneficiary Burden Estimate in Hours

	Upper Bound
Individual Beneficiary Hour Burden	1

[6] The initial field test of the pilot conducted by the Center for Program Integrity (CPI) Los Angeles Field Office found that interviews took an average of 0.25 hours, but SMEs with experience in home health fraud detection reported that such interviews may take about an hour. Given the small sample size of the initial field test and the minimal training in the pilot instruments given to interviewers in the Los Angeles Field Office, CMS is treating the time estimate from the initial field test as a lower-bound estimate and using the estimates from the SMEs as an upper bound.

Total Beneficiary Hour Burden (Indi. Burden x 2000 Claims)	2000

The beneficiary wage burden is calculated using an estimated wage of **$21.05 per hour**, which is the BLS mean hourly wage for all occupations. This hourly wage burden may overestimate the cost to the beneficiary, since many home health beneficiaries may be out of the labor force. However, there may be some beneficiaries who are employed, and there may also be beneficiary caregivers who participate in the interviews (for beneficiaries who are cognitively impaired or otherwise unable to respond) and who are employed. Multiplying this wage by the hour burdens reported in Table 1 produces estimates of the wage burden per beneficiary as well as for all beneficiaries in the sample. The beneficiary wage burden estimates are reported in Table 2.

Table 2: Beneficiary Burden Estimate in Wages

Occupational Code 31-1011	Total with Fringe Benefits
Individual Beneficiary Wage Burden (Individual Hour Burden x $21.35)	$21.05
Total Beneficiary Wage Burden (Total Hour Burden x $21.35)	$42,100.00

The hour and wage burden to the beneficiaries is estimated based on the following assumptions:

- Beneficiaries only need to answer questions to the best of their recollection.
- The instruments are completed by trained and experienced CMS and contractor staff, rather than the beneficiary.
- Beneficiaries are not required to maintain additional records to support this information collection.

HHA Interview Hour and Wage Burden

Based on the results of the pilot field test as well as interviews with SMEs, interviews with HHAs are expected to take from between one to two hours, with an average duration of 1.5 hours. To calculate the total hour burden for all HHAs in the sample the individual hour burden estimates are multiplied by 2000. The estimated hour burden per HHA as well as the estimated hour burden for the entire sample of HHAs is presented in Table 3.

Table 3: HHA Burden Estimate in Hours

	Upper Bound
Individual HHA Hour Burden	2
Total HHA Hour Burden (Individual Burden x 2000 Claims)	4000

The wage burden estimates for HHAs rely on BLS wage data for occupations listed under NAICS 621600 – Home Health Care Services. The estimated wage for HHA staff interviewed for the pilot is **$92.78 per hour**. This wage is the average of the mean hourly wages of three different BLS home health occupation categories: General and Operations Manager, Administrative Services Manager, and Medical and Health Services Manager. These occupation categories were selected based on feedback from the interviewers who conducted the pilot field test. Multiplying this wage by the hour burden estimates reported in Table 3 produces the wage burden estimates for individual HHAs as well as for all of the HHAs in the sample, reported below in Table 4.

Table 4: HHA Burden Estimate in Wages

Occupational Codes 11-1021; 11-3011; 11-9111	Total with Fringe Benefits
Individual HHA Wage Burden (Individual Hour Burden x $92.78)	$92.78
Total HHA Wage Burden (Total Hour Burden x $ 92.78)	$371,120.00

The hour and wage burden to the HHAs is estimated based on the following assumptions:

- The home health agency interviews will be administered by trained and experienced CMS and contractor staff.
- The estimated completion time includes the time spent by administrative staff locating and collecting requested documentation.

Referring Provider Interview Hour and Wage Burden

Based on the results of the pilot field test as well as interviews with SMEs, interviews with referring providers are expected to create a burden both for the physician and for an administrative staff member at each referring provider practice. Interviews with the physicians are estimated to take between 0.75 to 2 hours, with an average interview duration of 1.375 hours. Additionally, the administrative staff member is expected to spend between 0.167 and 0.333 hours collecting the requested documentation, with an average documentation collection time of 0.25 hours. The total hour burden estimate for the referring provider practice is the sum of the hour burden estimates for the physician and administrative staff member. The hour burden estimates for individual referring provider practices are reported in Table 5.

Table 5: Individual Referring Provider Practice Burden Estimate in Hours

	Upper Bound
Physician Hour Burden	2
Administrative Staff Hour Burden	0.333
Referring Provider Practice Hour Burden (Physician Hour Burden + Administrative Staff Hour Burden)	2.333

The wage burden estimates for referring providers rely on BLS wage data for occupations listed under NAICS 621100 – Office of Physicians. The estimated wage for physicians interviewed for the pilot is **$176.25 per hour**, which is the mean hourly wage for the occupation category Family and General Practitioners. The estimated wage for administrative staff that assemble documentation is **$32.17 per hour**, which is the mean hourly wage for the occupation category Administrative Services Manager. Multiplying these wages by the hour burden estimates reported in Table 5 produces the estimated wage burden estimates for both the physician and administrative staff member in a given referring provider practice, and the sum of those two estimates is the estimated wage burden for each referring provider practice. The wage burden estimates per referring provider practice are presented in Table 6.

Table 6: Individual Referring Provider Practice Burden Estimate in Wages

Occupational Code 29-1062; 43-9199	Total with Fringe Benefits
Physician Wage Burden (Hour Burden x $176.25)	$176.25
Administrative Staff Wage Burden (Hour Burden x $32.17)	$32.17
Referring Provider Practice Wage Burden (Physician Wage Burden + Administrative Staff Wage Burden)	$ 208.42

Multiplying the referring provider practice hour and wage burden estimates reported in Table 5 and 6 respectively by 2000 claims produces hour and wage burden estimates for the entire sample of referring provider practices. Those estimates are reported in Table 7.

Table 7: Total Referring Provider Practice Burden Estimate in Hours and Wages

Occupational Codes	Total with Fringe Benefits
Total Referring Provider Practice Hour Burden (Referring Provider Practice Hour Burden x 2000 Claims)	4666
Total Referring Provider Practice Wage Burden (Referring Provider Practice Wage Burden x 2000 Claims)	$ 972,487.72

The cost to referring providers is estimated based on the following assumptions:

- The referring provider interviews will be administered by trained and experienced CMS and contractor staff, and

- The estimated completion time includes the time spent by administrative staff locating and collecting requested documentation.

Total Hour and Wage Burden Estimates

The total hour and wage burden estimates for this information collection are the sum of the hour and wage burden estimates for the three sets of interview subjects described above. Table 8 provides the total hour burden estimate for this information collection.

Table 8: Total Information Collection Hour Burden

	Upper Bound
Total Beneficiary Hour Burden	2000
Total HHA Hour Burden	4000
Total Referring Provider Practice Hour Burden	4666
Total Information Collection Hour Burden	**10666**

Table 9 provides the total wage burden estimate for this information collection.

Table 9: Total Information Collection Wage Burden

	Total with Fringe Benefits
Total Beneficiary Wage Burden	$42,100.00
Total HHA Wage Burden	$371,120.00
Total Referring Provider Practice Wage Burden	972,487.72
Total Information Collection Wage Burden	**$1,385,707.77**

12b. Pre-Pilot Burden Estimates (Hours & Wages)

For each of the 130 claims in the pre-pilot sample, investigators will conduct interviews with the beneficiary, staff from the HHA, and the referring provider, as in the full pilot. Estimating the total burden in hours and wages for the pre-pilot requires (i) estimating the burden for each of these three separate groups of interview subjects, and (ii) summing each of these estimates to produce a total burden estimate. The process for completing these two steps is identical to the

process for calculating the burden estimate for the full pilot (described above in Section 12).

Beneficiary Interview Hour and Wage Burden

As in the full pilot, interviews with beneficiaries are expected to take from 0.25 to 1 hour, with an average duration of 0.625 hours. To calculate the estimated total hour burden for all beneficiaries in the sample the individual hour burden estimates are multiplied by 130. The estimated hour burden per beneficiary as well as the estimated hour burden for the entire sample of beneficiaries is presented in Table 9.

Table 9: Pre-Pilot Beneficiary Burden Estimate in Hours

	Upper Bound
Individual Beneficiary Hour Burden	1
Total Beneficiary Hour Burden (Individual Burden x 130 Claims)	130

The beneficiary wage burden is calculated using an estimated wage of **$21.05 per hour**, as in the full pilot. Multiplying this wage by the hour burdens reported in Table 9 produces estimates of the wage burden per beneficiary as well as for all beneficiaries in the pre-pilot sample. The beneficiary wage burden estimates are reported in Table 10.

Table 10: Pre-Pilot Beneficiary Burden Estimate in Wages

	Total with Fringe Benefits
Individual Beneficiary Wage Burden (Individual Hour Burden x $21.05)	$21.05
Total Beneficiary Wage Burden (Total Hour Burden x $21.05)	$2,736.50

HHA Interview Hour and Wage Burden

As in the full pilot, interviews with HHAs are expected to take from between one to two hours, with an average duration of 1.5 hours. To calculate the total hour burden for all HHAs in the sample the individual hour burden estimates are multiplied by 130. The estimated hour burden per HHA as well as the estimated hour burden for the entire sample of HHAs is presented in Table 11.

Table 11: Pre-Pilot HHA Burden Estimate in Hours

	Upper Bound
Individual HHA Hour Burden	2
Total HHA Hour Burden (Individual Burden x 130 Claims)	260

The estimated wage for HHA staff interviewed for the pilot is **$92.78 per hour,** as in the full pilot. Multiplying this wage by the hour burden estimates reported in Table 11 produces the wage burden estimates for individual HHAs as well as for all of the HHAs in the sample, reported below in Table 12.

Table 12: Pre-Pilot HHA Burden Estimate in Wages

	Total with Fringe Benefits
Individual HHA Wage Burden (Individual Hour Burden x $92.78)	$185.56
Total HHA Wage Burden (Total Hour Burden x $ 92.78)	$ 24,122.80

Referring Provider Interview Hour and Wage Burden

As in the full pilot, interviews with referring providers are expected to create a burden both for the physician and for an administrative staff member at each referring provider practice. Interviews with the physicians are estimated to take between 0.75 to 2 hours, with an average interview duration of 1.375 hours. Additionally, the administrative staff member is expected to spend between 0.167 and 0.333 hours collecting the requested documentation, with an average documentation collection time of 0.25 hours. The total hour burden estimate for the referring provider practice is the sum of the hour burden estimates for the physician and administrative staff member. The hour burden estimates for individual referring provider practices are reported in Table 13.

Table 13: Pre-Pilot Individual Referring Provider Practice Burden Estimate in Hours

	Upper Bound
Physician Hour Burden	2
Administrative Staff Hour Burden	0.333
Referring Provider Practice Hour Burden (Physician Hour Burden + Administrative Staff Hour Burden)	2.333

The estimated wage for physicians interviewed for the pilot is **$176.25 per hour**, and the estimated wage for administrative staff that assemble documentation is **$32.17 per hour**, as in the full pilot. Multiplying these wages by the hour burden estimates reported in Table 13 produces the estimated wage burden estimates for both the physician and administrative staff member in a given referring provider practice, and the sum of those two estimates is the estimated wage burden for each referring provider practice. The wage burden estimates per referring provider practice are presented in Table 14.

Table 14: Pre-Pilot Individual Referring Provider Practice Burden Estimate in Wages

	Upper Bound
Physician Wage Burden (Hour Burden x $86.09)	$176.25
Administrative Staff Wage Burden (Hour Burden x $32.17)	$32.17
Referring Provider Practice Wage Burden (Physician Wage Burden + Administrative Staff Wage Burden)	$208.42

Multiplying the referring provider practice hour and wage burden estimates reported in Table 13 and 14 respectively by 130 claims produces hour and wage burden estimates for the entire pre-pilot sample of referring provider practices. Those estimates are reported in Table 15.

Table 15: Pre-Pilot Total Referring Provider Practice Burden Estimate in Hours and Wages

	Upper Bound
Total Referring Provider Practice Hour Burden (Referring Provider Practice Hour Burden x 130 Claims)	303
Total Referring Provider Practice Wage Burden (Referring Provider Practice Wage Burden x 130 Claims)	$27,094.60

Total Hour and Wage Burden Estimates

The total hour and wage burden estimates for the pre-pilot sample are the sum of the hour and wage burden estimates for the three sets of interview subjects described above. Table 16 provides the total hour burden estimate for the pre-pilot sample.

Table 16: Total Pre-Pilot Hour Burden

	Upper Bound
Total Beneficiary Hour Burden	130
Total HHA Hour Burden	260
Total Referring Provider Practice Hour Burden	303
Total Information Collection Hour Burden	**693**

Table 17 provides the total wage burden estimate for the pre-pilot sample.

Table 17: Total Pre-Pilot Wage Burden

	Upper Bound
Total Beneficiary Wage Burden	$2,736.50
Total HHA Wage Burden	$24,679.48
Total Referring Provider Practice Wage Burden	$27,094.60
Total Information Collection Wage Burden	**$54,510.58**

13. Capital Costs

There is no annual cost burden to respondents or record keepers resulting from the collection of information beyond that described in item 12. All records collected from HHAs and referring providers are already maintained as required by 42 C.F.R. 424.516(f) paragraphs 1 and 2 and/or in accordance with accepted HHA or provider record-keeping practices.

14. Cost to Federal Government

CMS estimates that data collection will cost the government between $3.6 million and $5.5 million depending on where the beneficiaries in the random selection are located in the country. This estimate is based on the resources required to train interviewers, conduct the interviews, and support the infrastructure for centralizing the information collected.

15. Changes to Burden

Because the Probable Fraud Measurement Pilot is a new initiative, this calculation is not applicable.

16. Publication/Tabulation Dates

Specific information collected using the instruments will not be published. The resulting measurements of probable fraud may be published in summary form.

17. Expiration Date

CMS would like to display the expiration date.