Supporting Statement – Part A

Supporting Statement for Paperwork Reduction Act Submissions

A. Background

The Improper Payments Information Act (IPIA) of 2002 as amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012 requires CMS to produce national error rates for Medicaid and Children's Health Insurance Program (CHIP). To comply with the IPIA, CMS will engage a Federal contractor to produce the error rates in Medicaid and CHIP. The error rates for Medicaid and CHIP are calculated based on the reviews on three components of both Medicaid and CHIP program. They are: Fee-for-service claims medical reviews and data processing reviews, managed care claims data-processing reviews, and eligibility reviews. Each of the review components collects different types of information, and the state-specific error rates for each of the review components will be used to calculate an overall state-specific error rate, and the individual state-specific error rates will be used to produce a national error rate for Medicaid and CHIP. The managed care claims data is collected under OMB 0938-0994 (CMS – 10178) and the eligibility data is collected under OMB 0938-1012 (CMS – 10184).

OMB 0938-0994 (CMS – 10178) authorizes CMS to collect capitation payments information from the states for the purpose of measuring improper payments in Medicaid and CHIP in compliance with the IPIA requirement. The information collected will be used to conduct Medicaid and CHIP managed care data processing reviews as part of the state-specific error rates.

OMB 0938-1012 (CMS – 10184) authorizes CMS to collect forms for the eligibility review which collects sampling plan, monthly sample lists, review findings, payment findings, summary findings, eligibility error rates and corrective action report. Since the states conduct their own eligibility reviews, we collect their findings to calculate part of the state-specific error rates.

The states will be requested to submit, at their option, test data which include full claims details to the contractor prior to the quarterly submissions to detect potential problems in the dataset to and ensure the quality of the data. These states will be required to submit quarterly claims data to the contractor who will pull a statistically valid random sample, each quarter, by strata, so that medical and data processing reviews can be performed. State-specific error rates will be based on these review results.

For this collection OMB 0938-0974 (CMS – 10166), CMS needs to collect the fee-for-service claims data, medical policies, and other information from states as well as medical records from providers in order for the contractor to sample and review

adjudicated claims in those states selected for medical reviews and data processing reviews. Based on the reviews, state-specific error rates will be calculated which will serve as part of the basis for calculating national Medicaid and CHIP error rates.

The three collections within this program collect information for the different reviews in the program.

B. Justification

1. Need and Legal Basis

The collection of information is necessary for CMS to produce national error rates for Medicaid and CHIP as required by Public Law 107-300, the IPIA of 2002.

2. Information Users

The information collected from the states selected for review will be used to conduct claims reviews on which state-specific error rates will be calculated. The current fiscal year's quarterly claims data will be used by the Federal contractor to determine sample size and to sample claims for reviews. The medical policies will be used by the contractor to guide the medical review of the claims. Providers within the selected states whose claims were sampled for review will submit medical records on which the medical reviews will be based. The review findings will be used to calculate state-specific error rates on which national error rates for Medicaid and CHIP will be calculated.

The optional submission of test data will be used by the Federal contractor to detect potential concerns in the data sets to be submitted by the states to help avoid delays in the PERM measurement operation process.

3. Use of Information Technology

This information collection involves the use of electronic submission of information to the extent that states have the technological capability. CMS will not require states or providers to provide information electronically if they do not have secure systems in place to do so. While most states have claims information electronically, some states will likely submit information regarding claims in a hard copy format such as a tape. The percentage expected to be received electronically is less than 1 percent. The collection of information does not require a signature from the respondents.

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

The collection of information does not impact small businesses or other small entities.

6. Less Frequent Collection

Failure to acquire this data will prevent CMS from effectively measuring state-specific payment error rates on which to base national error rates for Medicaid and CHIP.

Consequently, CMS will not be able to produce error rates in a timely manner and would cause CMS to be out of compliance with IPIA.

7. Special Circumstances

CMS does not anticipate that states would be required to submit information more often than quarterly. States will provide quarterly claims data at the end of each quarter. States will also be required to submit medical policies at the beginning of being selected and updates on a quarterly basis at the end of each quarter. Submission of test data is optional.

8. Federal Register / Outside Consultation

The 60-day Federal Register notice published on April 8, 2016 (81 FR 20643).

9. Payments / Gifts to Respondents

There is no provision for any payment or gift to respondents associated with this reporting requirement.

10. Confidentiality

Confidentiality has been assured in accordance with Section 1902(a) (7) of the Social Security Act. This section provides safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. Any disclosure of information will be strictly for the use of the approved procedures.

11. Sensitive Questions

No questions of a sensitive nature are asked.

12. Burden Estimate (Total Hours & Wages)

The number of respondents is estimated to be up to 34 states (17 Medicaid and 17 CHIP programs per states). The annualized number of hours that may be required to respond to requests for information equals 56,100 hours (1,650 hours per state, per program) for a total cost of $3,339,072 (assumes the average hourly State pay is comparable to a 2016

Federal GS-12/l fully loaded rate with fringe and overhead costs calculated at 100% of the hourly wage and totaling $59.52 per hour).

It is estimated that each state will spend up to 1,650 hours annually, per program, to support this collection of information. The states will provide claims data on a quarterly basis for the following requests, per program:

i. Medicaid and CHIP FFS universes and claims detail information for each quarter (4) of the fiscal year for a total of 900 hours
ii. 250 hours for the submission collection and submission of policies with an estimate of 4 submissions -initial submission and quarterly updates.
iii. States will also be required to do the following for a total of 500 hours:
    1. Re-price claims determined to be in error. Errors are expected in less than 10 percent of sampled claims
    2. Inform the contractor of claims that were included in the sample but the adjudication decision changed due to the provider appealing the determination and the state overturning the claim
    3. Inform the contractor of provider enrollment information to assist in finding a provider associated with a sampled claim so that documentation can be obtained. It is expected that the contractor use common resources such as the internet, the phone book, and directory assistance before consulting the state. Erroneous provider demographic information, where resources other than the state are not available, is expected rare and estimated in less than 1 percent of sampled claims or < 10 requests.
    4. States will also be required to prepare and submit corrective action plans after error rates are determined for each program. This will be a single submission in the third year after state selection

The total burden per state per program is estimated to be 1,650 hours. It was determined that the request for medical documentation to substantiate claim submission is not a burden to individual providers nor is the request outside the customary and usual business practices of a Medicaid and/or CHIP provider. It is highly unlikely for a provider to be selected more than once, per program, per year to provide supporting documentation and due to the timeliness of the request for documentation, that information should be readily available and responses should take minimal time. Therefore, this request for information from providers is within the customary and usual business practice of a provider who accepts payment from an insurance provider whether it is a private organization, Medicaid or CHIP.

The following assumptions were used:

- The estimated number of states needed to produce a national error rate with the confidence and precision to meet the IPIA is up to 34 annually; 17 for Medicaid and 17 for CHIP.
- The estimated number of claims needed from each state to produce a state specific error rate with the confidence and precision needed to meet IPIA standards is estimated to be 500 per program.
- These 500 claims are going to be further stratified, based on service category.

- The 500 claims will be sampled over a full fiscal year of adjudicated claims by sampling a weighted number of claims each quarter, with the weight determined by quarterly expenditure data.

13. Capital Cost

There is no capital costs associated with this collection of information.

14. Cost to the Federal Government

We have estimated that it will cost $7.35 million annually for engaging Federal contractors to review FFS claims and calculate error rates in 34 State programs (17 States for Medicaid and 17 States for CHIP).

15. Changes to Burden

There are no changes to the burden.

16. Publication / Tabulation Dates

The calculated national error rate for both Medicaid and CHIP will be published annually in the Agency Financial Report (AFR).

17. Expiration Date

This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement

There are no statistical aspects of the certification form.