Supporting Statement for Information Collection of Medicaid and Children's Health Insurance (CHIP) Managed Care Claims and Related Information

A. Background

The Payment Error Rate Measurement (PERM) program measures improper payments for Medicaid and the State Children's Health Insurance Program (SCHIP). The program was designed to comply with the Improper Payments Information Act (IPIA) of 2002 and the Office of Management and Budget (OMB) guidance. Although OMB guidance requires error rate measurement for SCHIP, 2009 SCHIP legislation temporarily suspended PERM measurement for this program and changed to Children's Health Insurance Program (CHIP) effective April 01, 2009. See Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Public Law 111-3 for more details.

There are two phases of the PERM program, the measurement phase and the corrective action phase. PERM measures improper payments in Medicaid and CHIP and produces State and national-level error rates for each program. The error rates are based on reviews of Medicaid and CHIP fee-for-service (FFS) and managed care payments made in the Federal fiscal year under review. States conduct eligibility reviews and report eligibility related payment error rates also used in the national error rate calculation. CMS created a 17 State rotation cycle so that each State will participate in PERM once every three years. Following is the list of States in which CMS will measure improper payments over the next three years in Medicaid.

States Selected for Medicaid Improper Payment Measurements

Cycle 1 (FY 09,12,15)	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2 (FY 10,13,16)	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, new jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 3 (FY 11,14,17)	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, New York, Oregon, South Dakota, Texas, Washington

B. Justification

1 . Need and Legal Basis

CMS needs to collect capitation payment information from the selected States so that the federal contractor can draw a sample and review the managed care capitation payments. CMS will also collect State managed care contracts, rate schedules and updates to the contracts and rate schedules. This information will be used by the Federal contractor when

conducting the managed care claims reviews. Sections 1902(a)(6) and 2107(b)(1) of the Social Security Act grants CMS authority to collect information from the States.

The IPIA requires CMS to produce national error rates in Medicaid and CHIP fee-for-service, including the managed care component. The State-specific Medicaid managed care and CHIP managed care error rates will be based on reviews of managed care capitation payments in each program and will be used to produce national Medicaid managed care and CHIP managed care error rates.

2. Information Users

The information collected from the selected States will be used by Federal contractors to conduct Medicaid and CHIP managed care data processing reviews on which State-specific error rates will be calculated. The quarterly capitation payments will provide the contractor with the actual claims to be sampled. The managed care contracts, rate schedules, and updates to both, will be used by the federal contractor when conducting the managed care claims reviews.

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 to provide information electronically if they do not have secure systems in place to do so. The collection of information does not require a signature from respondents.

4. Duplication of Efforts

CMS does not approve CHIP managed care contracts and rates; therefore, we do not have this information on-hand. This information must be collected directly from the States and does not duplicate other collection of this information. For Medicaid, CMS approves managed care contracts and should be able to obtain these and other supporting information from its regional offices to the extent that the regional offices have the current information. The claims data information for Medicaid and CHIP can only be obtained from the States.

5. Small Businesses

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

6. Less Frequent Collection

Failure to acquire this certification form will prevent CMS from effectively measuring and producing State-specific and national managed care error rates in Medicaid and CHIP. As a result, CMS will be out of compliance with the IPIA.

7. Special Circumstances

CMS does not anticipate that States will be required to submit information more than initially and once a quarter in the year the States are reviewed. States will provide capitation payment information on a quarterly basis for a one-year period, once every three years.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice for this information collection 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. We will protect privacy to the extent provided by law.

11. Sensitive Questions

No questions of a sensitive nature shall be asked.

12. Burden Estimates (Hours & Wages)

On a rotational basis, CMS will measure Medicaid and CHIP managed care improper payments in up to 17 States per program.

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 28,050 hours (825 hours per state, per program) at a GS-12 step one rate of pay ($35.99) for a total cost of $1,009,520.

Federal Contracting Cost Estimate

We have estimated that it will cost $14.7 million annually for engaging Federal contractors to review FFS and managed care claims and calculate error rates in 34 State programs (17 States for Medicaid and 17 States for CHIP). We estimated these costs as follows: In the August 31, 2007 final rule, we estimated the Federal cost for use of Federal contractors conducting the FFS and managed care measurements to be $19.8 million annually. Due to more recent data acquired through our experience with Federal contractors in the FY 2007, FY 2008, and FY 2009 PERM cycles, we were able to produce a more accurate estimate by taking the average of Federal contracting costs for the three cycles and including anticipated future PERM cycle costs. The error rate measurements for 34 State programs (17 States for

Medicaid and 17 States for CHIP) would cost approximately $14,682,777 in Federal funds for the Federal contracting cost.

State Cost Estimate for and Managed Care Reviews

We estimated that total State cost for FFS and managed care reviews for 34 State programs is $6.2 million ($4,309,490 in Federal cost and $1,846,924 in State cost). This cost estimate is based on the cost for States to prepare and submit claims universe information for both FFS and managed care payments, prepare and submit claims details and provider information for sampled records, submit State program policies and updates on a quarterly basis, cooperate with Federal contractors during data processing review, participate in the difference resolution and appeals process, and prepare and submit a corrective action plan for claims errors. These costs are estimated as follows:

We estimated that the annualized number of hours required to respond to requests for required claims information for FFS and managed care review for 34 State programs will be 112,200 hours (3,300 hours per State per program). At the 2012 general schedule GS-12-01 rate of pay that includes fringe and overhead costs ($54.87/hour), we calculated a cost of $6.2 ($4,309,490 in Federal cost and $1,846,924 in State cost). This cost estimate includes the following estimated annualized hours: (1) up to 1,800 hours required for States to develop and submit required claims and capitation payments information; (2) up to 500 hours for the collection and submission of policies; and (3) up to 1,000 hours for States to cooperate with CMS and the Federal contractors on other aspects of the claims review and corrective action process.

Therefore, the total annual estimate of the State cost for 34 State programs to submit information for managed care reviews and participate with CMS and Federal contractors is $ 6.2m. ($4,309,490 in Federal cost and $1,846,924 in State cost).

13. Capital Costs

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

14. Cost to Federal Government

The Federal Government is going to engage a national contractor to determine the error rate for both Medicaid and CHIP. The error rate measurement for 34 State programs (17 States for Medicaid and 17 States for CHIP) would cost approximately $14,882,777 in Federal funds for the Federal contracting cost. The estimate for 34 response for the Fee-for-service (FFS) and managed care reviews are estimated to cost $6,156,414 ($4,309,490 in Federal cost and $1,846,924) based on an average of 1,000 claims reviewed.

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.