

Supporting Statement Part A  
Withholding Medicare Payments to Recover Medicaid Overpayments and  
Supporting Regulations in 42 CFR 447.31  
CMS-R-21, OMB 0938-0287

**BACKGROUND**

A substantial number of providers furnish health care services under both the Medicare and Medicaid programs, and are reimbursed according to the specific rules applicable to each program. Overpayments may occur in either program, at times resulting in a situation where an institution or person that provides services owes a repayment to one program while still receiving reimbursement from the other. This is appropriate since Federal funds support both.

In the past, when Medicaid overpayments occurred resulting in a situation where a provider of both Medicare and Medicaid services owed a repayment to the Medicaid program, the Federal Government had very limited authority under the Social Security Act to attempt recovery of overpayments.

Certain Medicaid providers that are subject to offsets for the collection of Medicaid overpayments may terminate or substantially reduce their participation in Medicaid, leaving the State Medicaid Agency unable to recover the amounts due. The recovery procedures allow for determining the amount of Medicaid overpayments and offsetting these overpayments by withholding the provider's Medicare payments. CMS will remit the amounts withheld from Medicare to the Medicaid State Agency to offset the overpayment under Title XIX (Medicaid).

To effectuate the withholding, the Medicaid State Agency must furnish the CMS Regional Office (RO) with certain documentation that identifies the provider and the Medicaid overpayment amount (that is, statement of reason for withholding, amount and type of overpayment, date overpayment was determined, closing date of pertinent cost reports, quarter in which overpayment was reported on quarterly expenditure report, as needed and upon request the names and addresses of provider's officers and owners at time of overpayment, reports of attempted contact with provider concerning overpayment recovery, and a copy of the provider's agreement with CMS). The Medicaid State Agency must also furnish documentation to show that the provider was notified of the overpayment and that demand for the overpayment was made. The data being requested is normally already accumulated in one form or another by the states and territories. Additionally, an opportunity to appeal the overpayment determination must have been afforded the provider by the Medicaid State Agency. Lastly, Medicaid State Agencies must notify CMS when to terminate the withholding.

This 2017 iteration proposes to extend OMB's expiration date by 3 years. It does not propose any program/burden changes or adjustments.

**A. JUSTIFICATION**

1. Need and Legal Basis

Section 2104 of the Omnibus Reconciliation Act of 1981 (Pub. L. 97-35) provides CMS with the authority to withhold Federal Medicare payments to recover Medicaid overpayments that the Medicaid State Agency has been unable to recover.

Effective June 10, 1985, regulation BPO-20-F was implemented to provide a remedy to this problem. The section of the regulation pertaining to recovery of Medicaid overpayments is codified at 42 CFR 447.31. It contains provisions giving CMS the authority to recover Medicaid overpayments by offsetting payments due to a provider under Medicare.

## 2. Information Users

When the CMS RO receives an overpayment case from the State Agency, the case file is examined to determine whether the conditions for withholding have been met. If the RO determines the case is appropriate for withholding Medicare payments, the RO will contact the institution's intermediary or individual's carrier to determine the amount of Medicare payments to which the entity would otherwise be entitled. The RO will then give notice to the intermediary/carrier to withhold the entity's Medicare payment.

## 3. Improved Information Technology

The occurrence of uncollectible overpayment cases is infrequent, and the information provided in each case will be different; therefore, this collection does not lend itself to computerization.

## 4. Duplication Similar Information

This collection does not duplicate any other collection.

## 5. Small Business

The respondents to this collection are Medicaid State Agencies, thus there is no effect on small businesses.

## 6. Less Frequent Collection

The information is reported on an as-needed basis. If the information was collected less frequently, CMS would not be able to implement this withholding procedure to recoup the Medicaid overpayment and the need for litigation in these overpayment situations would increase. Litigation is a more costly collection method.

## 7. Special Circumstances

The information is reported on an as-needed basis. Otherwise, there are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;

- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice / Outside Consultation

The 60-day notice published in the Federal Register on April 6, 2017 (82 FR 16843). No comments were received.

9. Payment or Gift to Respondents

There are no provisions for any payment or gift to respondents.

10. Confidentiality

While there are no assurances of confidentiality, the information is strictly for program use.

11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimate (Hours and Wages)

*Wages*

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates for all salary estimates ([http://www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm)). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the

adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefit (\$/hr)	Adjusted Hourly Wage (\$/hr)
Healthcare Support Workers (all other)	31-9099	18.13	18.13	36.26
Financial Specialist (all other)	13-2099	36.65	36.65	73.30

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

### *Burden Estimates*

The recovery procedure is part of 42 CFR 447.31(b), (c), and (d) which contains the following reporting requirements that are subject to the Paperwork Reduction Act of 1995:

Section 447.31(b) requires that Medicaid State Agencies give providers specific 30-day notice - by certified mail - before requesting CMS to offset Medicare payments.

Section 447.31(c) describes the documentation that Medicaid State Agencies must submit to CMS when requesting an offset to recover Medicaid overpayments.

Section 447.31(d) requires Medicaid State Agencies that have requested withholding to notify CMS to terminate withholding if the following occurs:

1. The Medicaid provider makes an agreement satisfactory to the Medicaid State Agency to repay the overpayment;
2. The Medicaid overpayment is completely recovered; or
3. The Medicaid State Agency determines that there is no overpayment, based on newly acquired evidence or subsequent audit.

There are 54 Medicaid State Agencies that provide Medicaid services. Based on past experience, we estimate that States and territories will utilize the aforementioned provisions 27 times<sup>1</sup> a year.

Agency experience with similar overpayment cases indicates that the time needed by a Medicaid State Agency to notify providers of offset, submit documentation to CMS and to notify CMS when to terminate withholding is 3 person hours (2 hours for a financial specialist and 1 hour for a healthcare support worker) per Medicaid overpayment case.

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<sup>1</sup> Some State Agencies will not have occasion to use this provision. However, for burden calculation purposes the average number of responses for each State Agency is assumed to be .5 cases per State. Thus, .5 per State multiplied by 54 State Agencies equals 27 cases multiplied by 3 hours per case.

54 Respondents (Medicaid State Agencies and territories)  
 27 Total responses annually  
 x 3 Hours per response  
 81 TOTAL HOURS

Costs to Medicaid State Agencies are computed at the hourly rate of \$36.26/hr for a healthcare support worker and \$73.30/hr for a financial specialist. The annual cost is \$4,937 (see burden summary table).

*Burden Summary*

Regulation	Annual Frequency	No. Respondents	Total Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost (\$/hr)	Total Cost (\$)
447.31(b), (c), and (d)	As needed	54	27	1 (financial specialist)	27	36.26	979.02
				2 (healthcare support worker)	54	73.30	3,958.20
<b>Total</b>	--	<b>54</b>	<b>27</b>	<b>3</b>	<b>81</b>	<b>Varies</b>	<b>4,937.22</b>

*Information Collection/Reporting Instruments and Instruction/Guidance Documents*

- 42 CFR 447.31(b), (c), and (d).

13. Capital Costs

There are no capital or annual operating costs associated with this collection.

14. Cost to Federal Government

The estimated time needed by the RO to perform their review function is 4 persons hours per overpayment case. Using the average grade and step of a GS-13, step 2, at an average hourly salary of \$46.94/hr x 4 hours, it would cost \$187.76 for each case. The total cost to the Federal Government would be \$5,069.52 (\$187.76 x 27 cases).

*Note: \$46.94/hr @ GS-13 step 2 for the Washington-Baltimore-Arlington locality (effective January 2017). See [https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2017/DCB\\_h.pdf](https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2017/DCB_h.pdf).*

15. Program/Burden Changes

There are no program/burden changes or adjustments.

16. Publication and Tabulation Dates

There are no publication or tabulation dates.

17. Expiration Date Publication

We will display the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.

**B. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS**

This collection does not employ statistical methods.