Supporting Statement – Part A
Payments for Services Furnished by Certain Primary Care Providers and Supporting Regulations in 42 CFR 438.6, 438.804, 447.405, and 447.415
CMS-10422, OMB 0938-New

BACKGROUND

The proposed rule, Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program (CMS-2370-P, RIN 0938-AQ63) would implement new requirements in sections 1902(a)(13), 1902(jj), 1932(f), and 1905(dd) of the Social Security Act, as amended by the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148; the Affordable Care Act). It implements Medicaid payment for primary care services furnished by certain physicians in calendar years (CYs) 2013 and 2014 at rates not less than the Medicare rates in effect in those CYs or, if greater, the payment rates that would be applicable in those CYs using the CY 2009 Medicare physician fee schedule conversion factor (CF). This minimum payment level applies to specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine, and also applies to services paid through Medicaid managed care plans. It would also provide for a 100 percent Federal matching rate for any increase in payment above the amounts that would be due for these services under the provisions of the State plan as of July 1, 2009. In this proposed rule, we specify which services and physicians qualify for the minimum payment level in CYs 2013 and 2014, and the method for calculating the payment amount and any increase for which increased Federal funding is due.

In addition, the proposed rule updates the interim regional maximum fees that providers may charge for the administration of pediatric vaccines to Federally vaccine-eligible children under the Pediatric Immunization Distribution Program, more commonly known as the Vaccines for Children (VFC) program.

In § 438.6(c)(3)(v) and (c)(5)(vi), States would be required to implement managed care contracts for payment to a MCO, PIPH or PAHP to comply with the requirements at section 1202 of HCERA. There is a one-time burden to the State for **amending such contracts** for the following provisions: (1) to assure that the level of payment is consistent with 42 CFR part 447, subpart G; (2) to assure that the specified physicians (whether directly or through a capitated arrangement) receive an amount at least equal to the amount set for and required under 42 CFR part 447; and (3) to assure that the State receive documentation regarding those payments.

In § 438.804(a)(3), States would be required to submit the methodology they intend to **use to identify the rate differential for managed care payments** to CMS for approval six months prior to the beginning of CY 2013 (that is, not later than June 30, 2012) and 6 months prior to CY 2014 (that is, not later than June 30, 2013). Further, we propose that, absent approval from CMS, States would not be able to claim the enhanced Federal match for managed care payments. All information described above must be collected no less than annually.

In § 447.400(a), States would be required to ensure that physicians **identify their specialty** to the Medicaid agency before an increased payment is made. Initial identification may be made by

self-attestation, but for program integrity purposes the State will be required to verify the physician's claimed specialty status by reviewing the Board certification status of the physician, or reviewing the physician's practice characteristics, before paying claims at the Medicare rate.

In § 447.410, States would be required to **submit a State Plan Amendment (SPA**) to reflect the fee schedule rate increases for eligible primary care physicians under section 1902(a)(13)(A) of the Act. The purpose of this proposed requirement is to assure that when States make the increased reimbursement to providers, they have State Plan authority to do so and they have notified providers of the change in reimbursement as required by Federal regulations.

A. JUSTIFICATION

1. Need and Legal Basis

States must submit information to document any expenditure eligible for 100 percent Federal matching funds. Section 1905 of the Social Security Act, as amended by section 1004(b) of this Act, as amended by section 1004(b) of this act and section 10201(c)(6) of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection.

"(dd) INCREASED FMAP FOR ADDITIONAL EXPENDITURES FOR PRIMARY CARE SERVICES.—Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbi shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence."

2. Information Users

The information will be used to document expenditures for the specified primary care services in the baseline period for the purpose of then calculating the expenditure eligible for 100 Federal matching funds in calendar years 2013 and 2014.

3. Use of Information Technology

Most information will be gathered through States existing MMIS billing systems. CMS anticipates that managed care data will be reported by managed care organizations (MCOs) to States outside of MMIS. We do not believe any process will require a signature from the respondent.

4. Duplication of Efforts

Fee for service expenditures data is already being gathered by States in order to process medical claims for payment. Managed care data is generally not being gathered by States although we believe that this information is currently reported by providers to MCOs. There is no known duplication of effort with respect to gathering data for fee for service payment and managed care.

5. Small Businesses

There is no known impact on small businesses.

6. Less Frequent Collection

If a State were not to collect information on the baseline expenditure for services paid fee for service and through managed care it would not have a supportable basis for claiming 100 percent Federal matching funds. If a State did not submit a State plan amendment and proceeded to change its reimbursement methodology the resulting expenditure would not be properly authorized through the Medicaid State plan. The related unauthorized expenditure would be subject to possible disallowance upon review by CMS.

7. Less Frequent Collection

If information were reported less frequently than indicated then States would not be able to properly identify timely those expenditures eligible for 100 Federal matching funds. This would have a potentially negative impact on State Medicaid programs.

8. Special Circumstances

There are no known special circumstances.

9. Federal Register/Outside Consulation

On May 11, 2012 (77 FR 27671), CMS published a propose rule (0938-AQ63) that solicits comments for 60-days on the PRA-related portions of that rule. CMS has not solicited outside consultation.

10. Payments/Gift to Respondents

There will be no payment or gift to respondents.

11. Confidentiality

CMS does not propose any assurance of confidentiality.

12. Sensitive Questions

There are no questions of a sensitive nature.

13. Burden Estimates (Hours & Wages)

Contract Requirements (§438.6)

The burden associated with the requirements under **§ 438.6(c)(3)(v) and (c)(5) (vi**) is the time and effort it would take each of the 35 State Medicaid programs and the District of Columbia (36 total respondents) to amend an average of three managed care contracts. We estimate it will take three hours to complete this task per contract at an estimated cost of $441.63 per respondent ($49.07/hr * 3 hr * 3 contracts) or $15,898.68 total ($441.63 per respondent * 36 respondents). In deriving this figure, we used a labor rate of $49.07/hr for a State's management, professional and related staff to amend each contract.

Additional Requirements (Methodology to Identify Rate Differential) for FFP for Managed Care Payments (§438.804(a)(2) and (3))

The burden associated with the requirements under **§ 438.804(a)(2) and (3)** is the time and effort it would take each of the 35 State Medicaid Programs and the District of Columbia (36 total respondents) to develop a methodology for the identification of payment made for primary care services through managed care contracts eligible for 100 percent Federal matching funds. This task will involve a one-time effort on the part of financial, legal and information technology staff. We estimate that it will take 14 hours per respondent at a cost of $637.42 to develop the identification methodology at a total cost of $22,947.12 (36 * $637.42).In deriving these figures, we used the following hourly labor rates and estimated the time to complete this task: $ 49.07/hr and 2 hours for legal staff to review the methodology for compliance with the statute ($98.14); $48.09/hr and 8 hours for managerial staff to assess the feasibility of implementing the methodology ($384.72); and $38.64/hr and 4 hours for information technology/public administration staff to assess the feasibility of the methodology ($154.56).

Provider Agreements (§441.505(b))

This requirement is exempt from OMB review and approval since we expect to receive fewer than 10 submissions (annually) from providers, if any. The requirement that providers must have provider agreements in place in order to participate in the VFC program has been in effect since the program was implemented in 1994. The provision in this regulation is merely codifying the requirement and no further action is necessary in regard to providers who are currently participating in the VFC program.

State Plan Amendments for the Vaccines for Children Program (§§441.510 and 441.515(d))

This requirement is exempt from the OMB review process as we expect to receive fewer than 10 submissions from States. The requirement that a State submit a State plan was a requirement when the VFC program was first established in 1994, and all States submitted State Plans at that time. A State now only submits a State plan amendment related to the VFC program when it makes a change to the State's administration fee. In 2011, only two States submitted State plans that made changes to the State's administration fee under the VFC program. Even with the

publication of the updated fee schedule, we do not anticipate that many States will make changes to their State's administration fee.

Eligible Services (§447.400(a))

The burden associated with the requirements under §**447.400(a)** is the time and effort it would take each of the 50 Medicaid Programs and the District of Columbia (51 total respondents) to establish that a physician is qualified, either through Board certification or a supporting claims history, to receive payment pursuant to section 1202 of HCERA. We estimate that it will take .5 hours to determine whether a physician may receive payment pursuant to section 1202 of HCERA. We used data from the Medicaid Statistical Information System (MSIS) to identify the number of physicians submitting claims for the E&M codes specified in this regulation during the fourth quarter of FY 08 and FY 09 (the most recent data available). Based on that data, there is an average of 2,245 physicians per State who currently bill, but whose eligibility for increased payment will need to be verified by the Medicaid agency. We increased this number by ten percent to account for participation by new physicians for a total of 2,470 physicians.

We used the following hourly labor rates and estimated the time to complete each task: one-half hour for a State's Medicaid office and support staff working in the medical billing area to retrieve and assess claims for an individual physician or one-half hour for administrative staff to review the Board certification status of a physician. Costs associated with these staff are reported at a cost of $14.12 for each half-hour derived from $28.24/hr each and 2,470 physicians for an estimated cost of $14.12 per response or $34,876.40 (total).

State Plan Requirements (§447.410)

The burden associated with the one-time requirement under **§447.410** is the time and effort it would take each of the 50 State Medicaid Programs and the District of Columbia (51 total respondents) to modify the Medicaid State plan to reflect payment consistent with the requirements in amended section 1902(a)(13)(C) of the Act. This will require the preparation and submission of a State plan amendment (SPA). We estimate that it will take State staff working 4 hours to complete all of the tasks associated with the preparation of a SPA. The estimated cost is $107.13 ($ 35.71/hr * 3 hr) per State or $5,463.63 total ($107.13 * 51) for tasks completed by non management staff working on SPA preparation. We estimate that this task will also require 1 hr for State-employed legal staff at $49.07/hr or $49.07 (per response) for a total of $2,502.57 ($49.07 * 51). The combined total for cost associated with SPA preparation, including non legal and legal staff employed by the State, is $7,966.20 ($5,463.63 + $2,502.57).

14. Capital Cost

There is no known capital cost associated with this collection of information. Rather, all cost is related to hours and wages reported above in part 12.

15. Cost to the Federal Government

The Federal government will not incur additional cost to for this information collection.

16. Changes to Burden

This is a new collection.

17. Publication/Tabulation Dates

Information will not be published.

18. Expiration Date

CMS would prefer not to display the expiration date.

19. Certification Statement

There are no known exceptions.

B. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

There are no statistical methods employed in this information collection.