

Application to Use Burden/Hours from Generic PRA Clearance:
Medicaid and CHIP State Plan, Waiver, and Program Submissions
(CMS-10398, OMB 0938-1148)

Information Collection #12 Increase in Primary Care Services Payments

December 2014

Center for Medicaid and CHIP Services (CMCS)

Centers for Medicare & Medicaid Services (CMS)

A. Background

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children's Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to elect new options available as a result of the Affordable Care Act or to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of health reform, including program waivers and demonstrations, and other technical assistance initiatives.

B. Description of Information Collection

The final rule 0938-AQ63 (CMS-2370-F) implements provisions of the Affordable Care Act, which require increased payments for certain Medicaid primary care services. Physicians that provide eligible primary care services must be paid at least the Medicare rates in effect in calendar years (CY) 2013 and 2014 for those services or, if greater, the payment rates that would be applicable in those years using the CY 2009 Medicare physician fee schedule conversion factor. Increased payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine or related subspecialists. States will receive 100 percent Federal financial participation (FFP) for the difference between the Medicaid State plan payment amount as of July 1, 2009, and the applicable Medicare rates in effect in CYs 2013 and 2014 for a set of Healthcare Common Procedure Coding System (HCPCS) codes used for evaluation and management (E&M) services and for certain Current Procedural Terminology (CPT) codes associated with vaccine administration. CMS has issued this final rule to promote uniform application of the payment by States and to clarify which providers and services qualify for payment.

In the final rule, under 42 CFR 447.410, states will be required to submit a SPA to reflect the fee schedule rate increases for eligible primary care physicians under section 1902(a)(13)(C) of the Act. They will also be required to submit a SPA that reflects the payment increase for vaccine administration. The purpose of this 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. In accordance with §447.205, public notification prior to the effective date of a SPA must be made whenever a state proposes a change to its methods and standards for setting payment rates for services. Consequently, the notification burden is included in the following estimate.

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 section 1902(a)(13)(C) of the Act. This will require the review, preparation, approval, and submission of a CMS-provided SPA template. We estimate that it will take state staff working 48 hours to complete all of the tasks associated with the review, preparation, approval, and submission of the SPA template. The estimated cost is \$ \$1,606.95 per state (\$35.71/hr x 45 hr) or \$81,954.45 total (\$1606.95 x 51) for tasks completed by non-management staff working on SPA preparation. We estimate that this task will also require 3 hour for state-employed legal staff at \$49.07/hr or \$147.21 (per response) for a total of \$7,507.71 (\$147.21 x 51). The combined total for cost associated with SPA preparation, including non legal and legal staff employed by the state, is \$89,462.16 (\$81,954.45 +\$7,507.71).

In order for a state to make the required enhanced primary care payment it must submit a Medicaid state plan amendment (SPA). This preprint represents a new page that a state may use to amend Attachment 4.19-B, which is the reimbursement section of the Medicaid state plan

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 86,240 hours, and CMS previously requested to use 17,940 hours, leaving our burden ceiling at 68,300 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 48 hours. There is a potential universe of 51 respondents, so the total burden deducted from the total for this request is 2,448 hours.

E. Timeline

Not applicable. This is an extension (without change) of a currently approved GenIC.

Attachments

The following attachment is provided for this information collection:

Attachment A – Reimbursement Template – Physician Services