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 #23 Medicaid Primary Care Payment Increase –

State Data Collection Tool

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

On November 6, 2012 CMS published 2370-F "Payments for Services Furnished by Certain Primary Care Physicians and Vaccines for Children Program." This final rule 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. 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 rendered by these provider types paid by Medicaid managed care plans contracted by states to provide the primary care services. It also provides for 100 percent federal financial participation (FFP) for any increase in payment above the amounts that would be due for these services under the provisions of the approved Medicaid state plan as of July 1, 2009. This rule also 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 Subpart G—Payment for Primary Care Services Furnished by Physicians at 42 CFR 447.400(d)(1) CMS requires that the state "must submit to CMS, in such form and such time as CMS specifies, information relating to participation by physicians described in paragraph (a) of this section and the utilization of E&M codes described in paragraph (c) of this section (whether furnished by or under the supervision of a physician described in paragraph (a)) of the section for the following periods—(i) as of July 1, 2009, and (ii) CY 2013 (2) As soon as practicable CMS will post this information on www.Medicaid.gov."

In accordance with the regulatory requirements CMS is formally requesting each state and the District of Columbia to submit data on physician participation and on payment rates in effect as of July 1, 2009, December 31, 2012 and January 1, 2013 and 2014. To minimize the administrative burden of completing this data collection tool we have developed a template in Excel for states to use in submitting their responses. There are three components/worksheets within the template: instructions to states, a spreadsheet to collect primary care rate data, and questions to gather information related to physician participation. States should submit their response by the dates indicated in the Data Collection Timeline to: (add dedicated mailbox

address here) using the OMB-approved template. Upon receipt of the state's response CMS will send an automated date-stamped reply by email.

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 37,236 hours, leaving our burden ceiling at 49,004 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 40 hours. There is a potential universe of 52 respondents, so the total burden deducted from the total for this request is 2,080 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:

- Data Collection Instructions - Medicaid Primary Care Payment Increase