Supporting Statement – Part A
Payments for Services Furnished by Certain Primary Care Providers and Supporting Regulations in 42 CFR 438.804, 447.400, and 447.410
CMS-10422, OMB 0938-1170 (New)

BACKGROUND

The final rule, Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program (CMS-2370-F; RIN 0938-AQ63) implements 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 also provides 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 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 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 § 438.804(a)(1), the rule provides that states are required to submit the methodologies they intend to use to identify the 2009 baseline rate for specified primary care services and the rate differential for managed care payments to CMS for review and approval by the end of the first quarter of CY 2013 (that is, not later than March 31, 2013). Further, absent CMS's approval of the methodologies, contract amendments and rates (as specified in §438.6), 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), the rule provides that states are required to ensure that physicians attest to either Board certification in one of the specialties or related subspecialties specified in statute or that they have a supporting claims history of furnishing the primary care services specified in statute before the Medicaid agency makes an increased payment. 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, the rule provides that states must determine the updated fee for service rate in CY 2014.

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 proposed rule (0938-AQ63) that solicited comments for 60-days on the PRA-related portions of that rule.

With regard to primary care provider payment increases (§438.804(a)(1) and (2)) we received comments maintaining that the proposed rule had significantly underestimated the costs of implementing this provision in a managed care delivery system. In response, we revised the burden estimates that were set out in the proposed 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)

To derive average costs, we used data from the U.S. Bureau of Labor Statistics for all salary estimates. The salary estimates include the cost of fringe benefits, calculated at approximately 35 percent of salary, which is based on the Bureau's June 2011 Employer Costs for Employee Compensation report.

Primary Care Provider Payment Increases (§438.804(a)(1) and (2))

In §438.804(a)(1) and (2), states are required to submit the methodologies they intend to use to develop a baseline for primary care service payments in 2009 as well as the differential between that baseline and the CY 2013 and 2014 rate to CMS for review and approval no later than the end of the first quarter of CY 2013. Further, we indicate that we will use those approved methodologies to review and approve managed care contracts and rates that are compliant with this provision.

The burden associated with the requirements under §438.804(a)(1) and (2) is the time and effort it would take each of the 37 state Medicaid programs and the District of Columbia (38 total respondents with managed care delivery systems) to develop both methodologies, as well as managed care capitation rates which reflect the increased payments to implement this section. The task of developing both methodologies will involve a one-time effort on the part of financial, legal and management staff, as well as significant contractual actuarial resources. Most of the 38 states use contracted actuarial firms to develop managed care capitation methodologies and rates. Since the development of the 2009 baseline and CYs 2013-2014 rate differentials require actuarial analysis, we have estimated those contractual costs. Once the methodologies are developed by each respondent's contracted actuary, each respondent will need to review and approve them prior to submission to CMS.

We estimate that it will take approximately 100 hours of contractual actuarial services per respondent at a cost of $5,398 to complete the data and actuarial analysis to develop these methodologies at a total cost of $205,124 (38 x $5,398). It will also take 10 hours per respondent at a cost of $482.86 to review and validate these methodologies in order to submit them to CMS at a total cost of $18,348.68 (38 x $482.86). In deriving these figures, we used the following hourly labor rates and estimated the time to complete this task: $53.98/hr and 100 hours for contracted actuarial staff; $49.07/hr and 2 hours for legal staff to review the methodology for compliance with the statute ($98.14); and $48.09/hr and 8 hours for managerial staff to review and submit these methodologies to CMS ($384.72). The total one-time burden amounts to $223,473 ($205,124 + $18,349).

Primary Care Services Furnished by Physicians with a Specified Specialty or Subspeciality (§447.400(a) and (b)

In §447.400(a), physicians are required to self-attest that they are Board certified in an eligible specialty or subspecialty or that 60 percent of the claims that they submit are for eligible E&M codes. In §447.400(b), at the end of CY 2013 and CY 2014, the state must review a statistically valid sample of physicians who received higher payments to verify that they meet the one requirement to which they attested.

The burden associated with the requirements under §447.400(a) and (b) is the time and effort it will take each of the 50 Medicaid Programs and the District of Columbia (51 total respondents) to establish a protocol for physician self-attestation and to conduct and review a statistically valid sample of "eligible" physicians once in each of CYs 2013 and 2014.

We used the following hourly labor rates and estimated the time to complete each task: 0.5 hours 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 0.5 hours 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 $34,876.40 per state ($14.12/hr x 2,470 responses/state) or $1,778,696.40 total ($34,876.40 x 51 states).

State Plan Requirements (§447.410)

The burden for states is the determination of the updated fee for service rate in CY 2014. We estimate that it will take state staff working 20 hours to set the new rate in accordance with the approved state plan amendment for this payment. The estimated cost is $607.07 ($35.71/hr x 17 hr) per state or $30,960.57 total ($607.07 x 51) for tasks completed by non-management staff working on SPA preparation. We estimate that this task will also require 3 hours 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 $38,468.28 ($30,960.57 +$7,507.71).

Summary of Annual Recordkeeping and Reporting Requirements and Associated Burden Estimates

Regulation Section(s)	**Respondents**	**Responses**	**Burden per Response (hours)**	**Total Annual Burden (hours)**	**Labor Cost of Reporting ($)**	**Total Cost ($)** (rounded)
§438.804(a) (1) and (2)	38	38 (total)	110	4,180	223,472.68	223,473
§447.400(a) and (b)	51	2,470 (per state) or 125,970 (total)	.50	1,235 (per state) or 62,985 (total)	34,876.40 (per state) or 1,778,696.4 (total)	1,778,696
§447.410 (amending FFS rate)	51	51 (total)	20	1,020	38,468.28	38,468
Total	--	--	--	68,185	2,040,637.36	2,040,637

14. Capital Cost

There is no known capital cost associated with this collection of information. Rather, all costs are related to the hours and wages reported in section 13 of this Supporting Statement.

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.

Since the publication of the proposed rule, a SPA template has been developed. Coinciding with the publication of the final rule, the requirements and burden associated with the SPA amendment have been removed from this PRA package. CMS is now seeking approval of the SPA-related requirements/burden estimates under OCN 0938-1148.

Additionally, with regard to primary care provider payment increases (§438.804(a)(1) and (2)) we received comments maintaining that the proposed rule had significantly underestimated the costs of implementing this provision in a managed care delivery system. In response, we revised the burden estimates that were set out in the proposed rule.

With regard to primary care services furnished by physicians with a specified specialty or subspeciality (§447.400(a) and (b)), the proposed rule estimated that it would take 0.5 hours to determine whether a physician may receive payment under the Affordable Care Act. In the final rule, we assessed the burden based on MSIS data from the fourth quarters of FY 2008 and 2009 which showed an average of 2,245 physicians per state who currently bill, but whose eligibility for increased payment would need to be verified by the Medicaid agency. We increased this number by 10 percent to account for participation by new physicians for a total of 2,470 physicians. The reported burden, which relies on a review of each physician qualifications, represents CMS's best estimate of the cost to sample data on physicians who self-attested. We relied on the data reported above in the absence of information about how each state plans to implement its sampling methodology.

While proposed in the NPRM, the final rule removed the provision that would have required states to verify the self-attestations of all physicians by confirming Board certification or an appropriate claims history. In the final rule, states must annually sample (in a statistically valid manner) the physicians who receive higher payment to ensure that they are either Board certified or that 60 percent of the codes they bill to Medicaid are the codes identified in this rule. We are not able to estimate this burden with greater precision due to lack of data about the varying methods states will use to fulfill this requirement (see discussion under the final rule preamble section A. *Payments to Physicians for Primary Care Services*; 1. Primary Care Services Furnished by Physicians with Specified Specialty and Subspecialty (§447.400); a. Specified Specialties and Subspecialties). Therefore, we have not modified our estimate of the impact of this section of the rule.

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.