



Medicaid Payments for Primary Care Services in Parity with Medicare & Charges for Vaccine Administration

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Executive Summary

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) released the [final regulation](#) which implements Section 1202 of the *Affordable Care Act*. This section increases Medicaid payments for specified primary care services to Medicare levels for certain primary care physicians in 2013 and 2014. In a [statement](#) released November 1, the AAFP welcomed the final regulation since bringing Medicaid payments up to par with Medicare for primary care and some preventive health services is a step in the right direction.

States will receive an estimated \$5.8 billion in 2013 and \$6.1 billion in 2014 in new federal funds to bolster their Medicaid primary care delivery systems. Unless Congress acts to extend and fund this provision permanently, a sudden return to disparate and inadequate payment for primary care services needed by Medicaid patients after only two years will again threaten to restrict their access to such needed services.

In early May 2012, CMS released the [proposed](#) version of this regulation, and in June, the AAFP reacted to the proposal by sending a formal regulatory comment [letter](#). In it, the AAFP generally supported the CMS mechanism to administer this additional payment but disagreed with the agency's proposal to allow sub-specialists to qualify, since the inclusion of sub-specialty physicians is not the intent of Section 1202 and would only serve to perpetuate existing disparities in physician payment policies.

In the final rule, CMS largely retained policies as originally proposed. The final rule provides for higher payment in both the fee for service and managed care settings for specific primary care services furnished by:

- Practicing physicians who self-attest that they are board certified with a specialty designation of family medicine, general internal medicine and pediatric medicine, or
- Subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American Osteopathic Association, or the American Board of Physician Specialties who also self-attest that they are board certified, or
- Physicians related to the specialty categories of family medicine, internal medicine and pediatrics who self-attest that at least 60 percent of all Medicaid services they bill or provide in a managed care environment are for the specified Evaluation & Management (E&M) and vaccine administration codes.
- Advanced practice clinicians when the services are furnished under a physician's personal supervision.

The final rule requires state governments to take further action prior to March 31, 2013, to implement this provision. So that low-income, working families and others can immediately benefit from this important provision, the AAFP calls on states to act quickly once CMS issues an anticipated template for a state plan amendment.

In addition to the increases in Medicaid payments, this regulation also updates vaccine administration fee maximums that had not been updated since the Vaccines for Children (VFC) program was established in 1994. CMS will use the Medicare Economic Index (MEI) to update the maximums consistent with inflation.

Eligible Physicians and Providers

The *Affordable Care Act* specifies that physicians with a specialty designation of family medicine, general internal medicine, and pediatric medicine qualify as primary care providers for purposes of this increased payment. CMS also finalized policy to qualify for higher payment the same designated services when provided by subspecialists related to the primary care specialists designated in the statute. These subspecialists would

be recognized by the [American Board of Medical Specialties](#), [American Osteopathic Association](#) and the [American Board of Physician Specialties](#).

Also eligible for the higher payment are physicians for whom the specified E&M and vaccine administration codes equal at least 60 percent of all the Medicaid services that they bill, or provide in a managed care environment. State Medicaid agencies may pay physicians based on their self-attestation alone or in conjunction with any other provider enrollment requirements that currently exist in the state. However, if a state relies on self-attestation, it must annually review a statistically valid sample of physicians who have self-attested that they are eligible primary care physicians to ensure that the physician is either board certified in an eligible specialty or subspecialty or that 60 percent of claims either billed or paid are eligible E&M and vaccine administration codes. In the case of services provided through a managed care delivery system, states will be given flexibility in the manner in which they perform this verification. CMS expects states to work with the health plans to determine an appropriate verification methodology.

This rule also stipulates higher payment for services provided under the personal supervision of eligible physicians by all advanced practice clinicians. In recognition of state efforts to enroll advanced practice clinicians in the Medicaid program and to require them to use their own Medicaid number, CMS removed the requirement that services be billed under the physician's billing number. However, CMS requires that the physician have professional oversight or responsibility for the services provided by the practitioners under his or her supervision.

Higher payments are for services provided by eligible physicians reimbursed pursuant to a physician fee schedule. Higher payment is not available for physicians who are reimbursed through a Federally Qualified Health Center (FQHC) or Rural Health Clinics (RHC) or health department/clinic encounter or visit rate or as part of a nursing facility per diem rate.

In the AAFP's comment [letter](#) on the proposal, the AAFP expressed concern that including subspecialists will add "unwarranted" costs. CMS responded to this concern, asserting that the agency continues:

"...to believe that the statute supports inclusion of subspecialists related to the three specialty categories designated in the statute and disagree that extending payments to subspecialists will dilute the impact of the regulation on Medicaid beneficiary access to primary care or result in "unwarranted" costs. The American Academy of Pediatrics cited the importance of pediatric subspecialists, particularly neonatologists, as a source of primary care services. The website of the American Academy of Family Physicians notes that primary care services can be delivered outside an office setting and that physicians who are not trained in the primary care specialties of family medicine, general internal medicine or general pediatrics may sometimes provide patient care services that are usually delivered by primary care physicians. This rule only provides for higher payment to subspecialists to the degree that they actually furnish the E&M codes specified in the regulation and, consequently, will not result in costs that are for services that are not properly considered primary care. Therefore, we continue to believe that all subspecialists related to the three specialty categories designated in the statute should be eligible for higher payment to the extent that they provide covered E&M services."

The *Affordable Care Act* requires that Medicaid managed care plans pay primary care physicians at the applicable Medicare rates. CMS will conduct a state-by-state review of managed care contracts to ensure they permit payment at the minimum Medicare primary care payment level.

Specified Primary Care Services

E&M codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 (or successor codes, where applicable) are eligible for higher payment. The agency also finalized policy to include the following E&M codes in that range that are not paid by Medicare:

- New Patient/Initial Comprehensive Preventive Medicine—codes 99381 - 99387;
- Established Patient/Periodic Comprehensive Preventive Medicine—codes 99391 - 99397;

- Counseling Risk Factor Reduction and Behavior Change Intervention—codes 99401 - 99404, 99408, 99409, 99411, 99412, 99420 and 99429;
- E&M/Non Face-to-Face physician service—codes 99441 - 99444.

Inclusion of a code on this list does not require a state to pay for the service if it is not already covered under the state's Medicaid program; it only requires the state to pay for the service at the Medicare rate if covered. All other state coverage and payment policy rules related to the service also remain in effect.

CMS had initially proposed that payment be adjusted for site of service and location of the service at issue. In the interests of administrative simplification, the final rule does not require states to make site-of-service adjustments in payments. Instead, CMS allows states to pay all codes at the Medicare office rate as an alternative to making site-of-service adjustments. For geographic adjustments, the final rule permits states either to make all appropriate geographic adjustments made by Medicare, or to develop rates based on the mean over all counties for each of the E&M codes specified in this rule.

For services unique to Medicaid for which relative value units (RVUs) have not been established by Medicare, CMS will develop and publish rates for eligible E&M codes not reimbursed by Medicare. In determining the 2013 and 2014 rates, CMS will use the 2009 conversion factor (\$36.07) only if that factor (in conjunction with the 2013 and 2014 RVUs) results in rates that are higher than if the 2013 and 2014 conversion factors were used. Medical practices will need to update their billing systems and then beginning in 2013, start billing Medicaid at the higher amount.

Updates to the Medicare Physician Fee Schedule

CMS recognizes the potential for multiple updates to the Medicare Physician Fee Schedule (MPFS) in 2013 and 2014. Rates published by CMS on or before November 1 of the preceding calendar year are often subject to periodic adjustments or updates throughout the year. The final rule permits states flexibility in determining whether, and how often, to update rates to conform to changes in the MPFS beyond the annual update. This applies to fee for service and managed care payment.

State Plan Requirements

CMS requires that states submit a State Plan Amendment (SPA) to reflect the fee schedule rate increases for eligible primary care physicians. According to CMS, the purpose of this requirement is "to assure that when states make the increased reimbursement to physicians, they have state plan authority to do so and they have notified physicians of the change in reimbursement as required by federal regulations." In the final rule, CMS indicates they will develop and then release within 2012 a template for use by states in implementing the requirements of this final rule.

In a separate discussion about availability of final 2013 Medicare RVUs, CMS reminds states that the agency does not:

...have the authority to permit states to implement higher payments "in phases." The statute requires that higher payment be made for services furnished on or after January 1, 2013. However, under regulations at §430.20, states have until March 31, 2013 to submit a State Plan Amendment (SPA) that is effective on January 1, 2013. Additionally, it is common practice for states changing reimbursement rates to make retroactive adjustments to claims after a SPA has been approved. This procedure provides additional time for states to make system changes to reflect this final rule and the November 2012 publication of the Medicare 2013 RVUs.

In the final rule, CMS discusses that the agency often takes 90 days or more to review and approve SPAs. In response to a question about whether the state should wait to implement the rate increase until the SPA is approved, CMS responded that:

The statute requires that states make higher payments for services provided on or after January 1, 2013. Our policy dictates that federal financial participation (FFP) is not available for services provided pursuant to an unapproved SPA. Therefore, as is the case with all rate changes, states can either make

the higher payments to physicians and wait to submit claims for FFP until the SPA is approved, or can pay physicians at the 2012 Medicaid state plan rates and make supplemental payments once the SPA is approved.

Theoretically, this means that a state could delay action until March 31 before submitting a SPA to CMS and if CMS takes another 90 days to review and approve the SPA, it could be six months or longer before eligible physicians and practitioners receive any of the higher payments. CMS requires states to make the higher payments as either add-ons to existing rates or as lump sum payments. To ensure that physicians receive the benefit of higher payments in a timely manner, the final rule indicates that “lump sum payments should be made no less frequently than quarterly”.

Federal Funding for Increased Payments for Vaccine Administration

The *Affordable Care Act* calls for an update to the interim regional maximum fees that providers may charge for the administration of pediatric vaccines to children who are eligible under the Vaccines for Children (VFC) program. The vaccine administration billing codes recognized for reimbursement under the statute are 90465, 90466, 90467, 90468, 90471, 90472, 90473 and 90474 or their successor codes.

This final rule defines the policy for additional payments for qualifying providers under the VFC program and establishes the 2009 Medicaid rate for vaccine administration. Because the immunization administration codes changed in 2011, states will need to determine the payment amount from other codes based on service volume. The service volume of code 90465 and of the pediatric claims for code 90471 will need to be imputed to determine the new payment amount for code 90460. In addition, VFC providers will be reimbursed at the lesser of the 2013 and 2014 Medicare rates or the maximum regional VFC amount in those years.

Medicaid Pay Varies Widely			
How much each state pays doctors for Medicaid primary care services compared to Medicare rates.			
AL	70%	KY	72%
AK	125%	LA	76%
AZ	86%	ME	64%
AR	69%	MD	74%
CA	43%	MA	70%
CO	77%	MI	51%
CT	72%	MN	47%
DE	98%	MS	90%
DC	94%	MO	57%
FL	50%	MT	102%
GA	70%	NE	76%
HI	59%	NV	71%
ID	91%	NH	62%
IL	53%	NJ	50%
IN	55%	NM	85%
IA	76%	NY	51%
KS	82%	NC	86%
		ND	141%
		OH	60%
		OK	95%
		OR	74%
		PA	56%
		RI	33%
		SC	79%
		SD	76%
		TX	62%
		UT	66%
		VT	83%
		VA	75%
		WA	72%
		WV	71%
		WI	61%
		WY	104%
		US Avg	61%

Source: The Urban Institute, 2010 figures.