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

Summary

Executive Summary
On May 9, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule that increases Medicaid payments for specified primary care services to Medicare levels for certain primary care physicians in 2013 and 2014. Also that day, AAFP Board Chair, Dr. Roland A. Goertz, joined CMS and Medicaid officials on a media call to announce this regulation and the AAFP issued a supportive statement.

The *Affordable Care Act* established these improved payment provisions for specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The increased payment also applies to services paid through Medicaid managed care plans. Payments to non-physician providers are not affected by this, though primary care services performed by a non-physician practitioner would be paid at the higher rates if properly billed under the provider number of a qualified physician, whether the services were furnished by the physician directly, or under the physician's personal supervision.

In total, states would receive more than $11 billion in new funds over two years to bolster their Medicaid primary care delivery systems. The federal agency will fully reimburse states for these increased payments. In the proposal and CMS press release, CMS recognizes that these provisions "are necessary to promote access to primary care services in the Medicaid program before 2014." CMS further states, "primary care for any population is critical to ensuring continuity of care, as well as to providing necessary preventive care, which improves overall health and can reduce health care costs."

In addition to the increases in Medicaid payments, this regulation also proposes updates to vaccine administration fee rates that have not been updated since the Vaccines for Children (VFC) program was established in 1994. CMS proposes using the Medicare Economic Index (MEI) to update these rates due to inflation.

The AAFP will send CMS comments on the proposal before the June 11, 2012 due date.

Eligible Physicians and Providers
Section 1902(a)(13)(C) of 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 says the agency is "particularly interested in ensuring that primary care physicians receive the benefit of the increased payment." Therefore, CMS proposes that to qualify at least 60 percent of codes billed by an eligible physician must be Evaluation & Management (E&M) codes and vaccine administration codes as specified in this regulation.

CMS proposes that services provided by subspecialists related to the primary care specialists designated in the statute would also qualify for higher payment. These subspecialists would be recognized in accordance with the designations of the American Board of Medical Specialties. As an

example, CMS includes that, “a pediatric cardiologist would qualify for payment if he or she rendered one of the specified primary care services by virtue of that physician’s subspecialty within the qualifying specialty of internal medicine.” CMS specifies that the inclusion of subspecialists is based on three points:

- That many primary care subspecialists render the primary care services specified in this rule. “Stakeholders, including physicians, states, and independent policy makers strongly emphasized the importance of subspecialists, particularly pediatric subspecialists, in the provision of primary care and strongly recommended that they be eligible for the higher payment.”
- CMS sees no justification for including only subspecialists in one specialty designation and, therefore, proposes that all subspecialists within the three specialty designations be eligible for increased payment for primary care services.
- CMS believes the statute provides the latitude to include related subspecialists within these specialty designations.

CMS proposes that states will be required to establish a system to identify the specialists and subspecialists eligible for increased payment. For program integrity purposes, the states will be required to confirm the self-attestation of the physician before paying claims with the increased payment. States will be required to confirm the self-attestation either by verifying that the physician is Board certified in an eligible specialty or subspecialty or through a review of the physician’s billing history.

To qualify based on billing history, CMS proposes that at least 60 percent of codes billed by an eligible, non-Board certified physician must be Evaluation & Management (E&M) codes and vaccine administration codes as specified in this regulation. Though this percentage threshold is not specified in the *Affordable Care Act*, CMS proposes this 60 percent threshold to ensure primary care physicians benefit from this provision and to mirror the Medicare Primary Care Incentive Program (PCIP). Unlike the PCIP, CMS proposes that verification would be based on the number of codes billed for the specified primary care services rather than charges. CMS discusses that, “the use of billing codes rather than allowed charges helps to assure that physicians providing a certain volume of primary care services are uniformly recognized for higher payment across states, regardless of variations in service charges.” CMS seeks comments on whether the 60 percent or some other percentage threshold is appropriate.

The *Affordable Care Act* requires that managed care plans pay primary care physicians at the applicable Medicare rates. CMS proposes to conduct a state-by-state review of managed care contracts to ensure they permit payment at the minimum Medicare primary care payment level. CMS will not require that managed care plans modify the terms of their payments to eligible primary care physicians beyond the increase in payments for primary care services required by the statute.

Increased payment would not be available for services provided in a federally qualified health center (FQHC) or rural health clinic (RHC).

The regulation discusses that “in Medicaid, many primary care physician services are actually furnished under the personal supervision of a physician by non-physician practitioners, such as nurse practitioners and physician assistants. Such services are billed under the supervising physician’s program enrollment number and are treated in both Medicare and Medicaid as services of the supervising physician.” Consistent with that treatment, CMS proposes that primary care services performed by a non-physician practitioner would be paid at the higher rates if properly billed under the provider number of a physician who is enrolled as one of the specified primary care specialists or

subspecialists, regardless of whether furnished by the physician directly, or under the physician's personal supervision. CMS does not propose to increase in payment for independently practicing nurse practitioners.

Specified Primary Care Services
CMS proposes that Healthcare Common Procedure Coding System (HCPCS) E&M codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors would be eligible for higher payment. These codes are specified in the *Affordable Care Act* and include primary care E&M codes not reimbursed by Medicare. CMS believes that the statute provides latitude to include codes not reimbursed by Medicare. Thus, the agency proposes to also include as primary care services the following E&M codes that are not reimbursed 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.

CMS proposes that states be required to use the Medicare Physician Fee Schedule rate applicable to site of service and geographic location of the service at issue.

For services unique to Medicaid for which relative value units (RVUs) have not been established by Medicare, CMS proposes to develop applicable RVUs in a separate fee scheduled developed by CMS and issued prior to 2013 and 2014. CMS seeks comments on the most appropriate way to set payment rates for services not reimbursed by Medicare.

Updates to the Medicare Physician Fee Schedule
CMS recognizes the potential for multiple updates to the Medicare Physician Fee Schedule in 2013 and 2014. Rates published by CMS on or before November 1st of the preceding calendar year are often subject to periodic adjustments or updates throughout the year. In addition, the Medicare rates vary by geographic location and site of service. CMS seeks comment on the proposal to permit states the option of either adopting annual rates or using a methodology to update rates to reflect changes made by Medicare during the year.

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.

In the proposed rule, CMS discusses details regarding "a number of factors affecting the identification of the cost of vaccine administration eligible for 100 percent federal financial participation" and that this is the first proposed update of the interim regional maximum administration fee since 1994. In 1994, under contract with the American Academy of Pediatrics (AAP), CMS purchased data on the normal fee AAP members charged for administering the vaccines that the VFC program covered. The final national average administration charge was $15.09. Claiming that no data is readily available on physician's actual costs, CMS proposes to use the Medicare Economic Index (MEI) to update the maximum administration fee based on the 1994 VFC value. Based on that approach, CMS determined that the updated national average administration charge would be $21.80.

In order to permit providers participating in the VFC program to benefit from the provisions of the *Affordable Care Act*, this rule proposes that states be required to reimburse VFC providers at the lesser of the 2013 and 2014 Medicare rates or the maximum regional VFC amount in those years. CMS seeks comments on this proposal. CMS included the following table in the proposed rule to compare the current and updated regional maximum fees by state.

TABLE 2—REGIONAL MAXIMUM ADMINISTRATION FEE BY STATE

State	Current regional maximum fee	Updated regional maximum fee
Alabama	$14.26	$19.79
Alaska	17.54	27.44
Arizona	15.43	21.33
Arkansas	13.30	19.54
California	17.55	26.03
Colorado	14.74	21.68
Connecticut	16.56	23.41
Delaware	16.55	22.07
District of Columbia	15.13	24.48
Florida	16.06	24.01
Georgia	14.81	21.93
Guam	.....	23.11
Hawaii	15.71	23.11
Idaho	14.34	20.13
Illinois	16.79	23.87
Indiana	14.47	20.32
Iowa	14.58	19.68
Kansas	14.80	20.26
Kentucky	14.17	19.93
Louisiana	15.22	21.30
Maine	14.37	21.58
Maryland	15.49	23.28
Massachusetts	15.78	23.29
Michigan	16.75	23.03
Minnesota	14.69	21.22
Mississippi	13.92	19.79
Missouri	15.07	21.53
Montana	14.13	21.32
Nebraska	13.58	19.82
Nevada	16.13	22.57
New Hampshire	14.51	22.02
New Jersey	16.34	24.23
New Mexico	14.28	20.80
New York	17.85	25.10
North Carolina	13.71	20.45
North Dakota	13.90	20.99
Ohio	14.67	21.25
Oklahoma	13.89	19.58
Oregon	15.19	21.96
Pennsylvania	15.76	23.14
Puerto Rico	12.24	16.80
Rhode Island	14.93	22.69
South Carolina	13.62	20.16
South Dakota	13.56	20.73
Tennessee	13.70	20.00
Texas	14.85	22.06
Utah	14.52	20.72
Vermont	13.86	21.22
Virginia	14.71	21.24
Virgin Islands	15.09	21.81
Washington	15.60	23.44
West Virginia	14.49	19.85
Wisconsin	15.02	20.83
Wyoming	14.31	21.72