Medicaid Primary Care Fee Increase Fact Sheet

On November 6, 2012 CMS released their final rule implementing the Medicaid payment increase for primary care services, required in the Patient Protection and Affordable Care Act passed by Congress on March 23, 2010.

- **What does the rule do?** This rule requires Medicaid payment for primary care services furnished in Calendar Years 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 affects Evaluation & Management (E&M) codes 99201-99499 to the extent that those codes are covered by the approved Medicaid state plan or included in managed care contracts. The 2009 base rate for codes not covered in 2009, but added after, will be $0. CMS will develop the rates for E&M codes not reimbursed by Medicare. This information will be made available on Medicaid.gov.

  Unlike Medicare, the final rule will not require states to adjust payment rates depending on the site of service. Instead, they can reimburse all services at the office rate, as opposed to the facility rate. The rule also allows states to decide whether they would like to make geographic adjustments in their rates (as Medicare does) **or** develop a rate based on the mean over all counties for each of the E&M codes specified in the rule.

  Additionally, a state is not required to cover all of the primary care service billing codes if it did not previously do so.

- **Why is it needed?** It is hoped that the higher payment will increase participation in the Medicaid program by eligible physicians, allowing for better access to primary and preventative care services by Medicaid beneficiaries as well as Medicaid's expansion in the coming years.

- **How does it affect states?** Under this rule, there is 100% federal financial participation for any increase in payment above that which would have been due for the same services under the provisions of the approved Medicaid state plan, as of July 1, 2009. Therefore, there is no additional cost above the 2009 levels to the states.

  The rule clarifies that states may defer to the state where the physician's practice is located with respect to a determination of a physician's eligibility for higher payment.

- **What is the economic impact?** The overall economic impact of this rule is estimated at $5.600 billion in CY 2013 and $5.745 billion in CY 2014.

- **Which specialties are affected?** This rule affects physicians with a specialty designation of family medicine, general internal medicine and pediatric medicine or subspecialties within these specialties, as defined by the American Board of Physician Specialties (ABPS), the American Osteopathic Association (AOA) and/or the American Board of Medical Specialists (ABMS) (*list available below*). Physicians must self attest to either be board certified in the specialty or subspecialty or self attest that sixty percent of all Medicaid services they bill or provide in managed care are for Evaluation & Management (E&M) and vaccine administrative codes. Individual states may allow the rate increase for physicians based on self attestation alone, or in conjunction with any other provider enrollment requirements that currently exist.

If states rely on self attestation only, it must annually review a statistically valid sample of physicians who have self attested to ensure that the physician is either Board certified under one of the specialties/subspecialties or that 60% of their claims billed or paid are for eligible E&M codes. In the case of Managed Care Organizations (MCO), states will be given the flexibility in the manner in which to perform verification.

Nurse practitioners working under the supervision of physicians will be able to collect the higher payment. Conversely, nurse practitioners independently enrolled will not be eligible for higher payment under this rule.

- **What about Managed Care?** This rule applies to all physicians under the designated specialties/subspecialties paid by Medicaid whether receiving payment on a fee for service basis, capitated or other Medicaid managed care plan. States must incorporate the requirement for increased payment into its contracts with managed care organizations and physicians must see the increase reflected in their salary. States will be given flexibility in developing a methodology to identify the base payment for these managed care delivery systems.

- **What are its limitations?** Higher payment is not available for physicians who are reimbursed through a FQHC, RHC or health department/clinic encounter or visit rate or as part of a nursing facility per diem rate.

- **When does it go into effect?** The new rule is effective Jan. 1, 2013. However, it is expected that many states will not be able to immediately comply and will have to provide the payment increases retroactively once the policy is put in place. It is required that states submit a State Plan Amendment by March 31, 2013, and begin implementing the rule thereafter.

Pediatric Immunization Distribution Program

- In addition to the fee increase for primary care physicians, the new rule also updated the interim regional maximum fees that may be charged for the administration of pediatric vaccines to federally vaccine-eligible children under the Pediatric Immunization Distribution program.
- Omnibus Budget Reconciliation Act of 1993 created the Vaccines for Children Program (VFC) in October 1, 1994. It requires that states provide a program for the purchase and distribution of pediatric vaccines to program registered providers for the immunization of vaccine eligible children. While the vaccine is provided free of charge, the patient can still be charged for administration. This rule updates the administration fee for the first time.
- This rule increases the maximum administration fee a state can charge, but under the VFC, a state must pay the lesser of (1) the Regional Maximum Administration Fee or (2) the Medicare fee schedule rate in CY 2013 or 2014.

Specialty List

** The ABPS does not certify subspecialists. Therefore eligible certifications are:*

- *American Board of Family Medicien Obstetrics*
- *Board of Certification in Family Practice*
- *Board of Certification in Internal Medicine*

There is no ABPS certification specific to Pediatrics.

American Board of Medical Specialties	American Osteopathic Association
Family Medicine	
Adolescent Medicine	
Geriatric Medicine	
Hospice and Palliative Medicine	
Sleep Medicine	
Sports Medicine	
Internal Medicine	
Adolescent Medicine	Allergy/Immunology
Advanced Heart Failure and Transplant Cardiology	Cardiology
Cardiovascular Disease	Endocrinology
Clincal Cardiac Electrophysiology	Gastroenterology
Critical Care Medicine	Hematology
Endocrinology, Diabetes and Metabolism	Hematology/Oncology
Gastroenterology	Infectious Disease
Geriatric Medicine	Pulmonary Disease
Hermatology	Nephrology
Hospice and Palliative Medicine	Oncology
Infectious Disease	Rheumatology
Interventional Cardiology	
Medical Oncology	
Nephrology	
Pulmonary Disease	
Rheumatology	
Sleep Medicine	
Sports Medicine	
Transplant Hepatology	
Pediatric Medicine	
Adolescent Medicine	Adolescent & Young Adult Medicine
Child Abuse Pediatrics	Neonatology
Developmental-Behavioral Pediatrics	Pediatric Allergy/Immunology
Hospice and Palliative Medicine	Pediatric Endocrinology
Medical Toxicology	Pediatric Pulmonology
Neonatal-Perinatal Medicine	
Neurodevelopmental Disabilities	
Pediatric Cardiology	
Pediatric Critical Care Medicine	
Pediatric Emergency Medicine	
Pediatric Endocrinology	
Pediatric Gastroenterology	
Pediatric Hematology-Oncology	
Pediatric Infectious Disease	
Pediatric Nephrology	
Pediatric Pulmonology	
Pediatric Rheumatology	
Pediatric Transplant Hepatology	
Sleep Medicine	
Sports Medicine	