Medicaid Payments for Services Furnished by Certain Primary Care Providers in CYs 2013 and 2014: Final Rule

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Overview

• As required by the Affordable Care Act sets Medicaid payment rates for certain services to at least Medicare rates for CYs 2013 and 2014

• For primary care services furnished by PCPs with specialty designation of:
  • Family Medicine
  • General Internal Medicine
  • Pediatric Medicine
  • And subspecialists of the above specialties

• Effective January 1, 2013

• 77 Fed. Reg. 66670, November 6, 2012
What’s Covered?

1. Physician services paid under fee-for-service (FFS), Medicaid managed care organizations (MCOs), and CHIP Medicaid expansion (CHIP stand-alone programs are not eligible)

2. Services provided by advanced practitioner clinicians (APCs) under the supervision of an eligible physician; billing can be under APC’s number
   - If APCs were reimbursed for services as of July 1, 2009 as percentage of physician fee schedule, then percentage payment is to be used 2013-14
Primary Care Services Covered

- E&M codes 99201 – 99499
- E&M Non Face-to-Face Physician Service: Codes – 99441 - 99444
- Vaccine administration codes
  - 90460, 90461, 90471, 90472, 90473, 90474
- 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 99444
Physician Eligibility

- Must meet specialty designation or be a subspecialist of a primary care specialty*
- Physicians self-attest to:
  - Board certification or
  - That at least 60% of all Medicaid services they provide are for the specified primary care codes
- Physician services delivered in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are not eligible for increased payments

*As determined by American Board of Medical Specialties, American Osteopathic Association and American Board of Physician Specialties
FFS Payments

• States have option to reimburse at Medicare office rate as alternative to making site of service adjustments

• States can either make all appropriate geographic adjustments made by Medicare or develop rates based on the mean over all counties for each code covered by rule

• CMS will develop a fee schedule for services unique to Medicaid
Managed Care Contracts

- States/MCOs will develop methodology for defining 2009 base rate
  - Deadline: end of first quarter CY2013
- CMS must approve of methodology before increased payments are provided
  - Eligible claims submitted in CY2013 before CMS approval will be reimbursed at CY2012 negotiated rates
    - Services paid at 2012 rates will be adjusted following CMS approval of methodology
Important for AMCs! Determining 2009 base rate

For both FFS and managed care payments:

- **Exclude** incentive, bonus, and performance-base supplemental payments

- **Include** other volume-based payments…
  - Particularly those associated with academic medical centers
  - REMEMBER: If state pays supplement it may apply to FFS, managed care, or both rates
    - Any rate brought above Medicare rate by a supplement does not receive the increase
States must demonstrate to CMS that the higher payments will be passed on for services furnished by PCPs

If state reduced payment below 2009 levels, Federal match only covers increase from 2009 levels and state is responsible for a portion of the increase

Ex:

- 2009 Medicaid rate - $100
- 2013 Medicaid rate - $90
- 2013 Medicare rate - $110
- State receives 100% match from 2009 rate ($10)
Updated Charges Under Vaccines for Children (VFC) Program

- Program is for children:
  - 18 or under and either Medicaid eligible or uninsured
- Updates the maximum fee that providers can charge for administering vaccines to children under the program
- Updated rates determined by Medicare Economic Index (MEI) formula.
  - Maximum administrative fee chart available at Vol. 77 Federal Register, No. 215, Pg. 66690