

CHAPTER 2



Medicaid Primary Care Physician Payment Increase

Key Points

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- ▶ The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) includes a provision that requires state Medicaid agencies to increase the payment rates of services furnished by certain primary care physicians in 2013 and 2014 to Medicare levels. The provision applies to fee-for-service fee schedules and Medicaid managed care organizations (MCOs). The federal government will fund the full cost of the difference between the prevailing fee schedule on July 1, 2009 and the 2013 and 2014 Medicare rates.
- ▶ In an effort to understand the operational and policy issues surrounding implementation of this provision and its potential effects on access, MACPAC conducted semi-structured interviews with six states (Alabama, California, Indiana, Massachusetts, Oregon, and Rhode Island) and the District of Columbia in late 2012 and early 2013. Several issues emerged during early implementation of the provision including:
 - Some states reported difficulty in identifying eligible providers.
 - States reported that the system modifications necessary for claims payment are more complex than routine payment rate changes, and require more time to implement.
 - Some states and MCOs noted that they would need to amend their contracts and adjust capitation payments in order to ensure that payment increases were passed through to physicians participating in Medicaid MCO networks.
- ▶ Several state Medicaid officials, Medicaid managed care staff, and provider organizations expressed concern that the effect of the provision on provider participation may be limited because it is set to expire after 2014.
- ▶ Six months into implementation, questions are already being raised about the effect of the payment increase. Evaluation efforts could use claims data to examine changes in service use. However, complete national claims data are not likely to be available until after the provision expires at the end of 2014. Surveys of physician attitudes or state-specific workforce data could provide useful information in a more timely fashion.

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The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) includes a provision that requires Medicaid to increase the payment rates of services furnished by certain primary care physicians in 2013 and 2014 to Medicare levels. This requirement is projected to increase Medicaid rates for these services by 73 percent on average in 2013, although there is significant variation around this average (Zuckerman and Goin 2012). Primary care rates in six states (Rhode Island, New York, California, Michigan, New Jersey, and Florida) are expected to double. On the other hand, rates in three states (Wyoming, Oklahoma, and Delaware) are likely to increase by less than 5 percent and rates in two other states (Alaska and North Dakota) are expected to remain the same. The federal government will fully fund the increase in payment rates.¹

The Commission's interest in this provision relates both to its work focusing on the implementation of the ACA and to more general issues of payment and access that are referenced in its statutory mandate. To better understand issues in implementation, we undertook a series of semi-structured interviews in several states with state Medicaid officials, Medicaid managed care organizations (MCOs), and provider organizations. Because these interviews took place in fall 2012 and early winter 2013, they primarily focused on state planning efforts and early issues encountered in implementation, concerns mirrored in official comments to the Centers for Medicare & Medicaid Services (CMS) in the rulemaking process. We also took the opportunity to explore state and stakeholder perspectives on the effect the payment increase might have on enrollee access to primary care and plans for evaluating its impact.

This chapter begins by describing the concerns that led to the inclusion of the payment rate increase in the ACA, including a review of previous research on the effect of payment increases on physician participation and enrollee access to care. Subsequent sections provide an overview of both statutory and regulatory requirements for states, and discuss some of the concerns that have surfaced as states proceed with implementation. The chapter concludes with a brief discussion of evaluation strategies.

Access to Primary Care and Physician Payment

Inclusion of the primary care rate increase in the ACA reflects two related concerns about access to care for Medicaid enrollees. First, there were particular concerns that the expansion of Medicaid eligibility to millions of additional enrollees could compromise access to primary care physicians for current Medicaid enrollees and result in higher levels of unmet need (Ku et al. 2011). For example, after Massachusetts enacted health insurance reforms in 2006, individuals reported longer wait times for office visits and more difficulty finding a doctor than they experienced prior to the reforms (KFF 2012, Long 2010).² But the provision also reflects more general concerns that low Medicaid physician payment rates (relative to other payers) affect physician participation in Medicaid, and thus access to care (Decker 2012, Cunningham and May 2006). While other factors, such as administrative burden, are also known to affect physician participation, the following section reviews what is known about the relationship between fee-for-service (FFS) payment rates and physician participation in Medicaid. The provision also affects managed care payments to physicians, an area that has been subject to less study.

Medicaid FFS physician payment rates are, on average, two-thirds of the rates that Medicare pays, although this varies by state and by service. In 2012, 38 states and the District of Columbia paid 85 percent of the Medicare rate or less for all physician services, while only 3 states offered rates that were higher than Medicare for all physician services on average (Zuckerman and Goin 2012).³

The disparity between Medicaid and Medicare payment rates is even larger for primary care services. In 2012, Medicaid payment rates for a representative sample of primary care services eligible for the ACA payment increase were

58 percent of Medicare rates. This disparity has increased recently: payments for these primary care services were 65 percent of Medicare's rates in 2008. However, the difference over time is due primarily to increases in Medicare's payments for certain physician services (Zuckerman and Goin 2012).

Because states have the authority to establish payment rates within broad federal parameters, Medicaid FFS physician rates vary across states. Nine states and the District of Columbia have reduced physician payment rates since July 1, 2009 (Ollove 2013).

The rate of physician participation in Medicaid has historically been considered an indicator of access. In a survey from 2004 and 2005, 21 percent of all physicians reported that they were not accepting new Medicaid patients (Cunningham and May 2006). In contrast, 4.3 percent reported that they were not accepting new privately insured patients, and 3.4 percent reported that they were not accepting new Medicare patients.

Lower rates relative to other payers are also associated with lower levels of physician participation. A 2012 study found that about 70 percent (69.4 percent) of physicians accepted new Medicaid patients in 2011. In contrast, 81.7 percent of physicians accepted new privately insured patients, and 83 percent accepted new Medicare enrollees. New Jersey (40.4 percent) and California (57.1 percent) had the lowest percentage of physicians accepting new Medicaid patients, and Minnesota (96.3 percent) and Wyoming (99.3 percent) had the highest. The study compared the share of physicians accepting new patients with the Medicaid-to-Medicare fee ratio in each state, and found that a 10 percentage point increase in the fee ratio correlated with a 4 percentage point increase in the acceptance of new Medicaid patients (Decker 2012).

Medicaid enrollees are more likely to see a physician in an outpatient setting or emergency room than a physician's office in states where rates are low relative to Medicare. One study found that as the Medicaid-to-Medicare fee ratio decreased (from 1 to 0.64), the likelihood of Medicaid enrollees receiving physician care in an outpatient hospital department or emergency department increased by 10.7 percentage points (Decker 2009). On the other hand, researchers have also demonstrated that higher payments increase the probability of Medicaid enrollees having a visit with a doctor or other health professional (Shen and Zuckerman 2005).

Payment rates are just one of several factors that affect physician participation in Medicaid. Physicians typically cite low rates as a major factor in not accepting new patients, but other factors—such as patient non-compliance, delayed payment, and paperwork requirements—rank close behind (Cunningham 2011, KFF 2011, Cunningham and Nichols 2005). About 70 percent of physicians said that billing requirements and paperwork were a moderate or very important reason for not accepting new Medicaid patients in a 2004 and 2005 survey, ranked second behind low payment rates (84 percent) (Cunningham and May 2006). In the same survey, physicians reported that Medicaid required more prior authorizations than private insurance carriers.⁴ Close to two-thirds (64.8 percent) of all physicians reported that delayed payment was a moderately or very important reason for not accepting new Medicaid patients.

Statutory and Regulatory Requirements for the Primary Care Physician Payment Increase

As noted above, the ACA requires that state Medicaid programs pay rates at least as high as Medicare rates for primary care services furnished by certain physicians in 2013 and 2014 (§1202). It also requires that states implement the rate increase in their Medicaid managed care programs as well as in FFS Medicaid. The federal government will fund the cost of the difference between the state's Medicaid fees as of July 1, 2009, and Medicare fees in 2013 and 2014 at a 100 percent federal matching rate. The nine states and the District of Columbia that reduced Medicaid physician rates since July 1, 2009, must fund the difference between their current rates and the prevailing rates on that date, at their usual federal medical assistance percentage (FMAP). The payment rate increase is expected to cost the federal government nearly \$11.9 billion over the two-year period and save state governments over \$500 million in provider payments for those states that have increased rates since July 1, 2009 (CMS 2012b).⁵ Costs incurred to Medicaid agencies in implementing the provision are not eligible for enhanced match.

CMS published a final rule for the implementation of the provision on November 6, 2012 (CMS 2012b), and has issued six further clarifying documents since then.⁶ Selected regulatory requirements are described below.

Eligibility for increased payments

Not all providers are eligible for increased payment rates under the ACA, nor are all services included. Eligibility requirements and the process for verification are described below.

Eligible services. The payment increase applies to evaluation and management services and some vaccine administration services. Evaluation and management services primarily include physician visits in which the physician takes a patient's history, examines the patient, and engages in medical decisionmaking or counseling.⁷

Eligible providers. The statute limits increased payment to physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. The final rule identifies eligible providers to include physicians practicing primary care with a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties, or the American Osteopathic Association (AOA).⁸ The rule also extends eligibility to physicians who are not board certified in a primary care field if they show that 60 percent of their Medicaid billed claims for the prior year (or previous month, for newly participating physicians) were for eligible services.⁹

Non-physician practitioners, such as advanced practice nurses and physician assistants, may be eligible for the payment increase if they provide primary care services under the supervision of an eligible provider. Physicians practicing in rural health clinics and federally qualified health centers are not eligible for the higher payments because these entities are governed by special payment rules and are classified under a different benefit category than specified in the Social Security Act.

Verification of eligibility. Physicians are required to self-attest to their eligibility by providing evidence of either board certification in one of the specialty or subspecialty designations, or an eligible claims history. The proposed rule had included a requirement that states verify the eligibility and self-attestation of each physician. Some states commented that this would be administratively burdensome and require costly modifications to

their Medicaid Management Information Systems (MMIS) used to process and adjudicate claims. In response, CMS amended the final rule and instead required states to retrospectively review a statistically valid sample of physicians receiving the higher payments in calendar year (CY) 2013 and CY 2014 to verify their eligibility for the payment.

CMS provided additional details and guidelines for the self-attestation process in further sub-regulatory guidance:

- ▶ States may establish reasonable time frames for providers to submit self-attestations (CMS 2013c). All providers will be eligible for increased rates on the date that they make their self-attestation but may also be eligible for services already provided dating back to January 1, 2013. Many states required that providers make their attestations prior to March 31, 2013, in order to receive retroactive payments. Other states will not provide retroactive eligibility (AAP 2013).
- ▶ States may require providers to resubmit self-attestations each year (CMS 2013c).
- ▶ Providers who participate in both Medicaid FFS and managed care are required to self-attest only once, effectively requiring state agencies to coordinate sharing of self-attestation information with managed care plans (CMS 2013a).
- ▶ States may delegate self-attestation collection to their contracted MCOs (CMS 2013a).

Payment amounts and frequency

States were required to submit a state plan amendment (SPA) with their proposed implementation procedures by March 31, 2013.¹⁰ This must include information on their payment amounts, payment type, and managed care methodologies, as described below.

Payment amount. The final rule provided some flexibility to states in determining their payment rates for eligible primary care services in 2013 and 2014. Medicare fees vary by geographic area and site of service (e.g., physician office versus hospital outpatient department). In response to state concerns about administrative complexity, CMS does not require states to vary their new Medicaid rates to the same extent. In their SPAs, states were required to indicate how they will address the following options in rate setting:

- ▶ **Geography.** States may pay the region-specific Medicare physician fee schedule rate or use an average rate for all counties.
- ▶ **Site of service.** States may implement site-of-service rate adjustments or pay one rate for each code, based on Medicare's rate for office-based services.
- ▶ **Provider type.** Some states also vary rates based on provider type, paying mid-level professionals a lower rate than physicians—for example, paying physician assistants providing services under the supervision of a physician 80 percent of the physician rate. The final rule stipulates that a state's mid-level professional payment methodology in place on July 1, 2009, must also be used for covered services and eligible providers under the primary care payment increase provision.

In addition to updating the rates paid for vaccine administration codes, the rule also updates the maximum regional administration fee that a provider may charge to administer vaccines to children eligible for the Vaccines for Children (VFC) program.¹¹

Payment type and frequency. The final rule provides states two alternatives for making payments to physicians:

- ▶ **Add-on to the existing fee schedule.** Under this option, states would adjust their fee

schedule to include the 2013 or 2014 Medicare rates and would provide the payment increase to physicians on a claim-by-claim basis.

- ▶ **Lump-sum supplemental payment.** If states do not wish to adjust payments for each claim, they may calculate the additional amount owed to each physician and pay the amount in a lump sum quarterly or more frequently.

States were required to specify in their SPAs which methodology they will use. And while CMS may adjust the Medicare physician fee schedule more than once annually, the final rule allows states the option to adjust their fee schedule each time a new Medicare physician fee schedule is published or once annually.

Managed care. Medicaid MCOs must comply with the ACA primary care payment provision in 2013 and 2014. This obligation must be specified in the states' contracts with the MCOs. For each MCO contract, the state is required to submit to CMS the methodologies the state will use to identify the services covered by the payment, to calculate the amounts owed, and to verify that MCOs delivered the enhanced primary care rate to eligible providers.

CMS developed a framework for states that could assist them in this process. CMS has also issued two additional question and answer documents for implementation in managed care settings that answer eligible provider, eligible payment, and operational questions specific to MCOs (CMS 2013b, CMS 2012d).

Interaction with Medicare payments for dual eligibles. The payment increase will also affect physicians who provide care to individuals dually eligible for both Medicare and Medicaid. Medicare is the primary payer for primary care services for these individuals, and Medicaid covers cost sharing. However, in many states, Medicaid pays the lesser of the Medicare cost-sharing amount

or the difference between the Medicaid rate and the amount already paid by Medicare—effectively limiting the physician’s total payment to the Medicaid rate when it is lower than Medicare’s rate. (For a more complete discussion of these lesser-of policies, see MACPAC’s March 2013 report to the Congress.) When Medicaid physician fees are paid at Medicare rates in 2013 and 2014, primary care physicians serving dual eligibles under lesser-of policies should receive full payment of Medicare coinsurance.

Issues Emerging from Early Implementation

The primary care payment increase provision is simple in concept, but has proven difficult to operationalize. Although states routinely make changes to their fee schedules and payment policies, this provision is distinguished by the fact that the changes are federally mandated for specific services provided by specific physicians. States must make administrative changes in order to comply with these requirements— changes that are not easy to make, particularly within the short time frame between the publication of the final rule and the effective date of the provision. The requirement that the payment increase also apply to managed care represents an additional layer of complexity.

In order to better understand the challenges associated with implementation, MACPAC conducted semi-structured interviews with officials from six states (Alabama, California, Indiana, Massachusetts, Oregon, and Rhode Island) and the District of Columbia.¹² Interviews were conducted from mid-October 2012 through January 2013, and most state Medicaid policy officials were interviewed around the time the final rule was published in November. This meant that state Medicaid officials were either anticipating or

analyzing the final rule, and staff responded to our interviews with some uncertainty about how to proceed with implementation issues such as site-of-service and geographic adjustments to their fee schedules, proposed requirements that were eventually made optional in the final rule.

These interviews and subsequent conversations with Medicaid officials and other stakeholders brought to light concerns in six areas: modifying claims-processing systems, identifying eligible providers, the exclusion of mid-level and non-physician practitioners, aligning with current payment methodology, the time allotted to implement the provision, and the temporary nature of the provision. The discussion below highlights the themes raised in the interviews, many of which were reinforced by comments on CMS’ proposed rule and more recent reports from states, provider associations, and others.

MMIS modifications. Although states make rate adjustments routinely, the MMIS changes required to implement the primary care payment increase are not routine, and the administrative costs of making them will be matched at the usual FMAP. The data systems changes essentially require new functions: flagging providers as eligible or ineligible for a rate increase based on self-attestation, paying two rates for a specific code depending on provider eligibility, and tracking and reporting the amount spent on the increased rates to CMS for enhanced federal match. Such changes have to be programmed into the MMIS system and then tested.

Identifying eligible providers. States consistently reported that determining which providers would be eligible for the rate increase based on specialty or subspecialty is both complex and burdensome. States must develop and implement a self-attestation process for providers that is unique to the primary care payment increase. Moreover, not all states routinely collect board certification

information from their providers. Additionally, states reported not having complete encounter and FFS claims data to determine eligibility for providers who participate in both FFS Medicaid and MCOs and are seeking eligibility under the 60 percent billed code threshold. States must also coordinate the self-attestation process with their managed care contractors.

Non-physician providers. Some states interviewed indicated that the effect of the provision on access to care may be limited because the statute excludes independently practicing non-physician practitioners. Some states rely on these providers, particularly in underserved and rural areas.¹³ And for non-physician practitioners practicing under the supervision of a physician, the state must verify that the supervising physician has self-attested to his or her eligibility, another possible layer of complexity.

Aligning alternative payment methods. Not all states use procedure codes in the same way, and aligning alternative payment methods with Medicare's payment rates can be a challenge. For example, some states will pay for pediatric vaccine administration using the service codes associated with the vaccines instead of the vaccine administration codes.¹⁴ The requirement that states pay at Medicare rates for certain codes makes it necessary for states to crosswalk codes unique to their state with those used by Medicare, and, in some cases, amend their payment policy.

In some cases, states indicated that the provision conflicts with other efforts to implement alternative payment methods. For example, some states are considering accountable care organizations or bundled payments as alternatives to traditional FFS methods. Among states that are implementing alternative payment methods, the primary care rate increase means that while they are moving away from the traditional volume-based FFS system, they have to maintain some form of

it to ensure their compliance with the primary care rate increase provisions.

Implementation time frame. Publication of the final rule on November 6, 2012, gave states little time to be ready for making increased payments on January 1, 2013. In addition to the systems changes and provider outreach activities described above (which may include additional steps in a managed care environment, discussed later), each state had to submit a SPA. All states were able to meet CMS' March 31, 2013, deadline to submit their SPA, and as of mid-June, SPAs had been approved for nearly half of the states. Thus, only these states were allowed to make increased payments five months after the effective date of the provision. At the time of our interviews, state Medicaid officials had anticipated delays and were planning to make at least some increased payments to providers retroactively, even in states that planned to implement the provision as an add-on to the standing fee schedule.

Primary care rates in 2015 and beyond. A consistent theme from MACPAC's interviews was a concern that the effect of the provision on provider participation may be limited because it is set to expire after 2014. Several of the states included in our interviews indicated that they are unlikely to be able to maintain the rates in 2015 and beyond without the enhanced federal matching funds. For example, the California legislature passed a law in June 2012 (AB 1467 [Monning], Chapter 23, Statutes of 2012), that mandated that rates return to pre-2013 levels in 2015 unless the enhanced federal match continues. Others voiced concern that rolling back rates in 2015 to pre-2013 levels would be perceived as a rate reduction rather than a discontinuation of the rate increase and could negatively affect provider recruitment efforts. Such concerns were also cited as a rationale for making lump-sum supplemental payments rather than incremental additional payments for

each primary care claim. Similarly, some states reported concerns that because the rate increase is temporary, it will not provide enough incentive for non-participating physicians to become Medicaid providers.

Implementation Issues Specific to Managed Care

Many of the challenges reported by states in implementing the provision within FFS extend to managed care, including identifying eligible providers, modifying administrative systems, and coordinating attestation. In addition, states must develop a methodology to adjust payments to MCOs to account for the increase in spending on eligible services and report this amount for enhanced federal funding. This requires contracting with actuaries to calculate and certify rates, and then amending contracts with managed care plans to reflect new rates.

Managed care rate setting. States typically pay participating managed care plans through a capitation payment—a fixed payment for a defined package of benefits, usually paid on a per member per month basis.¹⁵ The methodology that states use to determine these capitation rates must be certified by actuaries and approved by CMS. To meet the requirements of the statute, states must adjust those methodologies to pass the primary care increase through to eligible physicians and identify the payment amount eligible for full federal funding.

CMS published technical guidance that states could use for this task, proposing three risk models that would generally be considered reasonable and acceptable and would deliver enhanced payment to eligible physicians participating in managed care networks:

- ▶ **Full-risk prospective capitation.** The state calculates the capitation rates for 2013 and 2014 inclusive of the primary care rate increase. This model shifts financial risk entirely to the managed care plan because there would be no reconciliation to actual utilization.
- ▶ **Prospective capitation with risk sharing that incorporates retrospective reconciliation.** The state calculates the capitation rates for 2013 and 2014 inclusive of the primary care rate increase but retrospectively analyzes encounter data and reconciles payments to the plans to ensure that capitation payments were sufficient to cover the rate increase. States may reimburse plans for the full amount of any shortfall, or use a risk-sharing arrangement so that the state only gives the plan additional funds for costs outside of a specified risk corridor.
- ▶ **Non-risk reconciled payments for enhanced rates.** The state makes 2013 and 2014 capitation payments to managed care contractors without adjusting for the primary care rate increase. Instead, the managed care contractor reports primary care service utilization at some interval (e.g., quarterly), and the state reviews the report and pays accordingly.

According to CMS, every state has proposed to use one of these models (CMS 2013d). In some cases, states have customized the model to better fit their program (Mercer 2013).

Under any of these models, states must make a judgment about the share of capitation payments that is attributable to eligible primary care services at the Current Procedural Terminology (CPT) code level. This task is challenging because MCOs may use varying payment methods to compensate providers (Mercer 2013). For example, MCOs may employ salaried physicians or use sub-capitated agreements. Neither method is tied to the volume

or type of services the physician provides. MCOs may also use a different coding system that would require a crosswalk, perhaps imperfect, to those used in the Medicare physician fee schedule.

When calculating the additional primary care payment for MCOs, states must also decide whether to calculate a single, average amount for all enrollees or to vary the payment across different subgroups to reflect differences in their utilization of the eligible primary care services. Calculating the impact at this rate-cell level might better align payment to take into account differences in plans' enrollment mix, but would likely be more difficult to administer (Mercer 2013).

Also at issue is the availability of data to conduct the provider and procedure-level analyses required to calculate the level of rate increases. Actuaries typically use plan encounter data and financial statements, which may not have sufficient detail for this purpose.

Managed care contract amendments. Finally, states must renegotiate contracts with MCOs, a source of concern among state officials in our interviews.¹⁶ Some states anticipated this in late 2012 and either put contract changes on hold or put in placeholders for the payment increase during contract negotiations with MCOs. They anticipated amending those contracts upon receipt of formal guidance and approval of their plans from CMS. CMS will use approved SPAs and payment increase methodologies in their approval of contract amendments.

Evaluation

Given the limited two-year time period that the primary care payment increase will be in effect, questions are already being raised as to whether an extension of the policy is warranted. Although prior research suggests an association between

relatively higher physician fees and physician participation, it is not clear whether this scenario will be borne out.

At the time of our interviews, state officials were more focused on implementation than evaluation. Moreover, complete national claims data that could be used to examine changes in service use will not be available until well after the payment increase expires at the end of 2014. On the other hand, surveys of physician attitudes or state-specific workforce data could provide useful information in a more timely fashion.

States are required to submit certain physician participation and utilization information, pre- and post-implementation, to CMS (42 CFR 447.400(d)). CMS will specify the format that states will use to submit data and when submissions are due, and is likely to elaborate on what information is expected at that time. The regulation requires CMS to make the information from states available on the Medicaid website. State-specific information that includes participation among non-physician practitioners, as well as provider specialty and subspecialty details, could prove useful in assessing the effect of the provision in advance of a more comprehensive and systematic evaluation.

Efforts to implement the primary care payment increase are ongoing, and we can expect more states to begin making increased payments as they receive SPA approval. As states transition to day-to-day operation, more information will become available. In the months ahead, the Commission will continue to monitor implementation and will be looking at efforts of state, federal, and academic evaluators to see what can be learned to inform future work.

Endnotes

¹ The increase, as described later in this chapter, is the difference between the prevailing fee schedule on July 1, 2009, and the 2013 and 2014 Medicare rates. This difference is fully funded by the federal government; administrative costs associated with implementing this change are funded at a state's usual FMAP.

² The Massachusetts reform had some positive effects: more people reported having a usual source of care, and the number of people who had one physician office visit in the past year increased (Long and Masi 2009). On the other hand, individuals' reported level of unmet need was nearly at the same level it was pre-reform.

³ Published Medicaid FFS rates may not reflect total payments to physicians. In fiscal year 2012, 20 states made supplemental payments to physicians, typically those employed by state university hospitals (MACPAC 2013). These payments are made in addition to the standard fee schedule payments.

⁴ Prior authorization is the requirement that a provider must obtain prior approval from a health insurer (including Medicaid) before providing a service to an enrollee. Without this approval, the insurer may deny a claim and not pay the provider for the service.

⁵ These figures represent aggregate projections. The state savings come with two caveats. The first is that savings figures do not include administrative costs incurred by states as they operationalize the provision. Secondly, some states will have to pay the difference between current rates and the rates as of July 1, 2009, with their usual federal match.

⁶ The first two documents came out at the same time as the final rule (CMS 2012c and 2012d). An additional set came out in 2012 (CMS 2012a), and three more have been published in 2013 (CMS 2013a, 2013b, and 2013c).

⁷ Evaluation and management codes are designated as codes 99201 through 99499 in the CPT code set. The vaccine administration services covered by the payment provision are CPT codes 90460 and 90461 for administration and counseling related to children's vaccines, and 90471–90474 for other vaccine administration. For codes for which there is no Medicare rate, CMS will publish applicable rates. States with alternative methodologies for paying for vaccine administration may also be eligible to increase those rates in an equivalent manner, subject to CMS approval.

⁸ The ABMS recognizes approximately five eligible family medicine subspecialties, and some examples include adolescent medicine, geriatric medicine, and sports medicine. Among the list of internal medicine subspecialties recognized by ABMS (19 total) and AOA (11 total), some examples include diabetes and metabolism, gastroenterology, and rheumatology. Among the list of pediatric subspecialties recognized by ABMS (20 total) and AOA (5 total), some examples include neonatology or neonatal-perinatal medicine, pediatric allergy and immunology, and pediatric pulmonology. CMS has published additional information in a question and answer document (CMS 2012b).

⁹ Sub-regulatory guidance offered an example of a physician who is board certified in dermatology and who practices in the community as a family practitioner. This physician would be eligible if he or she could support his or her attestation with 60 percent claims history.

¹⁰ SPAs may be made retroactive to the first day of the federal fiscal quarter in which they were submitted to CMS. For example, the primary care payment increase was scheduled to become effective on January 1, 2013. Therefore, states had until March 31, 2013, to submit the SPA so that they could make retroactive payments for services provided on or after January 1, 2013.

¹¹ The VFC program was authorized in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66, as amended). The program makes vaccines available to providers at no cost, who must administer the vaccines to children who cannot otherwise pay. The final rule published for the primary care payment increase updates the amount that providers may charge for the administration of vaccines, although providers may not charge for the vaccines themselves.

¹² States were selected based on three criteria: (1) states with the potential to derive a significant benefit from the increase (i.e., those with a Medicaid-to-Medicare fee ratio of 0.9 or less based on 2008 data), (2) states with different potential challenges in implementing the payment increase, and (3) states from different regions of the country. To ensure inclusion of states facing different implementation challenges, we included states representing different levels of managed care penetration and with different physician payment arrangements.

¹³ States have the authority to pay health care professionals other than physicians, such as certified nurse practitioners and nurse midwives, and states have differing requirements as to what extent these professionals are paid based on physician fee schedules.

¹⁴ State health departments and other local and territorial public health agencies distribute vaccines to private providers at no charge through the VFC program. Under these circumstances, the vaccines are not eligible for payment. Because of this, some states may use the service codes associated with the vaccine to pay providers for the administration of the vaccine instead of the codes set aside for vaccine administration.

¹⁵ For more discussion of managed care payment policy, see Section D of MACPAC's June 2011 report to the Congress.

¹⁶ Contracts with MCOs serving Medicaid enrollees are required by CMS to include a provision that allows a state to amend the contract to come into compliance with a newly issued legislative mandate.

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