On November 6, 2012, the Centers for Medicare and Medicaid Services (CMS) officially published the final regulation in the Federal Register to implement Section 1202 of the Affordable Care Act (ACA), which requires state Medicaid agencies to reimburse at least as much as Medicare rates for primary care services provided by specified physicians in calendar year 2013 and 2014. The final regulation includes pediatric specialists and subspecialists as eligible providers for the payment increase. The increased Medicaid payment for primary care services applies to services provided on a fee-for-service basis and those paid by Medicaid managed care plans. The final regulation defines eligible physicians, identifies eligible primary care services, and delineates implementation guidance for states. States will receive 100 percent federal matching funds for the increased Medicaid rates. The regulation represents an over $11 billion increase in Medicaid funds for states over two years.

The final rule also updates the fees that providers may charge for the administration of pediatric vaccines under the Vaccines for Children program.

The following summary highlights the provisions in the rule that are most relevant to children’s hospitals and their patients.

**PAYMENTS TO PHYSICIANS FOR PRIMARY CARE SERVICES**

**Eligible Providers**
The final rule specifies that physicians with a specialty designation of family medicine, general internal medicine and pediatric medicine are primary care providers for purposes of the increased Medicaid payment. Further, all subspecialties recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) within the three designations (family medicine, general internal medicine and pediatric medicine) are eligible for the increased payment.

- Pediatric subspecialties eligible for Medicaid payment increase – The following chart lists those pediatric subspecialties that would be eligible for increased Medicaid payments under the final rule. According to their website, the ABPS does not include pediatric specialties.
Pediatric Subspecialties Recognized by ABMS

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Speciality</th>
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<tbody>
<tr>
<td>Adolescent Medicine</td>
<td>Pediatric Endocrinology</td>
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<tr>
<td>Child Abuse Pediatrics</td>
<td>Pediatric Gastroenterology</td>
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<tr>
<td>Developmental-Behavioral Pediatrics</td>
<td>Pediatric Hematology-Oncoology</td>
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<tr>
<td>Hospice and Palliative Medicine</td>
<td>Pediatric Infectious Disease</td>
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<tr>
<td>Medical Toxicology</td>
<td>Pediatric Nephrology</td>
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<tr>
<td>Neonatal-Perinatal Medicine</td>
<td>Pediatric Pulmonology</td>
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<tr>
<td>Neurodevelopmental Disabilities</td>
<td>Pediatric Rheumatology</td>
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<tr>
<td>Pediatric Cardiology</td>
<td>Pediatric Transplant Hepatology</td>
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<tr>
<td>Pediatric Critical Care Medicine</td>
<td>Sleep Medicine</td>
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<tr>
<td>Pediatric Emergency Medicine</td>
<td>Sports Medicine</td>
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</table>

Pediatric Subspecialties Recognized by AOA

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<thead>
<tr>
<th>Speciality</th>
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<tbody>
<tr>
<td>Adolescent and Young Adult Medicine</td>
<td>Pediatric Endocrinology</td>
</tr>
<tr>
<td>Neonatology</td>
<td>Pediatric Pulmonology</td>
</tr>
<tr>
<td>Pediatric Allergy/Immunology</td>
<td>Sports Medicine</td>
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<tr>
<td>Pediatric Endocrinology</td>
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- Pediatric surgery and obstetrics/gynecology physicians are among the specialists and subspecialists that would not be included. Others include child and adolescent psychiatry, pediatric radiology, and pediatric urology. These physicians are not tied to the specialty designations outlined in the statute.

- Eligible services provided by all advanced practice clinicians providing services within their scope of practice under the supervision of an eligible physician will be eligible for the higher payment.

- Physicians practicing in federally qualified health centers and rural health centers are not eligible for the increased payment. The physicians in these settings are reimbursed as facilities and receive cost-based reimbursement under the Medicaid prospective payment system.

Under the final rule, physicians will self-attest that he/she:

- Is Board certified with such a specialty or subspecialty outlined above or

- Has furnished evaluation and management (E&M) services and vaccine administration services under the codes described in the rule that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.
State Medicaid agencies can pay physicians on their self-attestation alone or in conjunction with any other provider enrollment requirements that currently exist in that state. If the state relies on self-attestation, then at the end of each year of the payment increase the state is required to review a statistically valid sample of physicians who received higher payments to verify that they meet the requirements to be an eligible physician under this rule. In the case of services provided through Medicaid managed care plans, states have flexibility in the manner in which they verify the providers’ eligibility for the payment increase.

The state is allowed to defer to the state where the physician’s practice is located with respect to a physician’s eligibility for the increased payment. If a Medicaid beneficiary receives eligible services out-of-network from a provider covered by this rule, the payment rate must also align with the rule requirements.

The final rule clarifies that the higher payment does apply to services paid under Medicaid expansion Children’s Health Insurance Programs (CHIP), but not CHIP separate programs.

**Eligible Primary Care Services**
CMS includes all primary care services outlined in the statute, including those not covered by Medicare.

- Under the rule, 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 are eligible for higher payment.

- The rule requires state Medicaid agencies to reimburse the specified codes at the higher rate to the extent that those codes are covered by the approved Medicaid state plan or included in a managed care contract. The 2009 base rate for codes not covered in 2009 but subsequently added will be $0. For example, if a state begins paying for a certain code in 2013 that it had not previously paid for, then the state would receive the difference between $0 and the Medicare rate at the 100 percent federal matching rate. To ensure that states do not add a large number of codes now that 100 percent matching funds are available, CMS will monitor states that add codes not covered in 2009. CMS will not pay for codes that the state has decided not to cover (e.g. prolonged services, care plan management, and telephone management).

**Payment for Eligible Services**
The final rule implements Medicaid payment for primary care services furnished by certain physicians in calendar years 2013 and 2014 at rates not less than Medicare rates in effect in those calendar years or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor.

- The rule requires payment not less than the amount that applies under the Medicare Physician Fee Schedule that is applicable to the site of service or, at state option, the office setting and is also adjusted for geographic location of the service or reflects the mean over all counties of the rate for each evaluation and management code. States are allowed to reimburse all codes at the Medicare office rate as an alternative to making site of service adjustments. The state is required to outline what methodology it has chosen in its state plan amendment.
• The higher payments may be made as add-ons to existing rates or as lump sum payments. If a state chooses to pay in lump sum payments, the payments must be made no less frequently than quarterly.

• States have the flexibility to determine whether to, and how often to, update rates to conform to changes in the Medicare physician fee schedule

• CMS will establish and publish the rates for non-Medicare reimbursed services using the Medicare conversion factor in effect in calendar years 2013 and 2014 (or the calendar year 2009 conversion factor, if higher) and the relative value units for 2013 and 2014

State Plan Requirements
CMS requires states to submit a state plan amendment to reflect the fee schedule rate increases for eligible primary care physicians to ensure that states have the authority and have notified physicians of the reimbursement change.

• Higher payment must be made for services provided on or after January 1, 2013, but existing state plan procedures will allow states some flexibility in timing. Current state plan amendment procedures allow states until March 31, 2013 to get their state plan amendment approved. The state could then pay at the higher rate until the state plan amendment is approved or wait until it is approved to access the federal matching funds and pay retroactive to January 1.

• The state plan must identify all eligible codes that the state will reimburse at the Medicare rate in 2013 and 2014 and identify all codes that were not reimbursed under the Medicare as of July 1, 2009.

• In the state plan amendment, the state must specify if it will make all adjustments applicable to the specific site of service or, at state option, the office setting and will also adjust for specific geographic location of the service or pay rates that reflect the mean over all counties of the rate for each evaluation and management code. The state must specify the formula it will use to determine the mean rate for each evaluation and management code.

• CMS will develop a state plan amendment template for use by states in implementing this policy.

Federal Financial Participation
Under the ACA, states will receive 100 percent federal matching funds for expenditures equal to the difference between the Medicaid state plan rate for primary care services in effect on July 1, 2009, and the Medicare rate in effect in calendar years 2013 and 2014 (or the payment rate that would be applicable using the calendar year 2009 Medicare conversion factor, if greater). If a state lowered rates after July 1, 2009 then the state would receive the regular federal matching rate for the difference between the lowered rate and the Medicaid rate in effect on July 1, 2009.

• For purposes of calculating the payment made under the approved state plan in effect on July 1, 2009, the state must exclude incentive, bonus and performance-based payments but must
include all supplemental payments for which the approved methodology is linked to volume and payment for specific codes.

Primary Care Service Payments Made by Managed Care Plans
The ACA requires Medicaid managed care plans to pay physicians at the applicable Medicare rates for primary care services. The Medicaid managed care plans are required to submit documentation to the state, to enable the state and CMS to ensure that provider payments increase as required under the rule.

The state must submit to CMS the following methodologies for review and approval:

• A reasonable methodology for identifying provider payments that would have been made by Medicaid managed care plans for primary care services as of July 1, 2009; and

• A reasonable methodology for identifying the differential in payment between the provider payments that would have been made by Medicaid managed care plans on July 1, 2009 and the amount needed to comply the higher payments for primary care services

The state must submit the methodologies to CMS for review no later than March 31, 2013. CMS will use the approved methodologies required in the review and approval of Medicaid managed care contracts.

Federal Funding for Increased Payment for Vaccine Administration
The rule also updates the interim regional maximum fees that providers may charge for the administration of pediatric vaccines to federally vaccine-eligible children under the Vaccine for Children Program.

If you have any questions on the final regulation, please contact Aimee Ossman or 703-797-6023.