American College of Physicians

Analysis of the "Medicaid Parity" Final Rule
(November 7, 2012)

Proposed Rule Comments by ACP	Final Rule with Details
This proposed rule recognizes that ready access to primary care services is a core goal of the Medicaid program, and attempts to ensure through increased payments that a sufficient number of primary care physicians and related specialists /subspecialists participate in the program to meet the needs of this expanded population. More specifically this proposed rule would implement Medicaid payment for primary care services furnished by primary care and related physicians in calendar years 2013 and 2014 at rates not less than the Medicare rates in effect in those years. The federal government would be responsible for the total cost of these added payments during this time period The College is very supportive of the overall goal of this proposed rule and generally supports the specific regulations the rule defines.	This final rule implements Medicaid payment for primary care services furnished by certain physicians in calendar years (CYs) 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. The increased payment is available to eligible physicians participating in a state Medicaid program or a Children's Health Insurance Program (CHIP) structured as an expansion of the state's Medicaid program. The increased payment is not available to physicians delivering services within a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) since payment for these programs is made on a facility rather than a services delivered basis. Payment for designated services will be at the rate of 100 percent of the fee as reflected in the Medicare Physician Fee Schedule (PFS). The rate is the full fee---there is no deducted beneficiary co-pay.

Proposed Rule Comments by ACP	Final Rule with Details
	The PFS rate used to calculate the increase does not include the Medicare Primary Care Bonus payment to eligible physicians implemented as part of section 5501 of the Affordable care Act. The 2009 base rate for Medicare PFS codes not covered in 2009 but subsequently added will be $0. CMS will develop and publish rates for eligible E&M codes not reimbursed by Medicare. In determining the 2013 and 2014 rates, we will use the 2009 conversion factor, if that factor in conjunction with the 2013 and 2014 RVUs results in rates that are higher than if the 2013 and 2014 conversion factors were used. The final rule provides for a 100 percent federal matching rate for any increase in payment above the amounts that were due for these services under the provisions of the state plan as of July 1, 2009. There is no cost to states for these increased payments. The higher payments may be provided either as add-on to existing rates or as a lump sum payment. In order to decrease administrative burden and provide administrative flexibility to the states: • The final rule does not require that states make site of service adjustments to the PFS amounts. This rule provides that states may reimburse all codes at the Medicare office rate as an alternative to making site of service adjustments. • The final rule additionally permits states to either make all appropriate geographic adjustments made by Medicare to

Proposed Rule Comments by ACP	Final Rule with Details
	the PFS amounts, or to develop rates based on the mean over all counties for each of the E&M codes specified in this rule. • The final rule permits states flexibility in determining whether to, and how often to, update rates to changes in the PFS. **These elements are consistent with the proposed rule and are supported by the College.**
The College commends CMS for the broad definition used in defining those physicians eligible for these increased payments. The definition includes primary care specialists (family medicine, internal medicine and pediatrics) and the subspecialists related to these primary care specialty areas through their respective certifying boards. It also qualifies those physicians that provide at least 60 % of codes billed from the set of defined primary care codes. The broad definition recognizes that the delivery of primary care services is not restricted to traditional primary care specialists, but is often provided by primary care subspecialists and other physicians.	This final rule provides for higher payment in both the fee for service and managed care settings to physicians practicing within the scope of practice of medicine or osteopathy with a specialty designation of family medicine, general internal medicine and pediatric medicine. It also provides for higher payment for subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American Osteopathic Association and the American Board of Physician Specialties. Physicians who are in those designated specialties but not board certified (are Board eligible) can also qualify if at least 60 percent of the codes billed by the physician for all of CY 2012 be for the E&M codes and vaccine administration codes specified in this regulation. The final rule indicates that evidence of fulfillment of one of these requirements can be made solely through self-attestation. To further clarify, physicians in specialties (and related subspecialties) other than internal medicine, family medicine and pediatrics are not eligible for the higher payments even if 60% of the codes billed by the physician for all of CY 2012 are for the

Proposed Rule Comments by ACP	Final Rule with Details
	E&M and vaccine administration codes specified in the rule. Therefore, OB/GYNs and other physicians without the above designations are not eligible for the higher payment. The final rule removes the requirement included in the proposed rule that the State Medicaid agency verify the self-attestation of all physicians by confirming Board certification or an appropriate claims history. State Medicaid agencies may pay physicians based on their self-attestation alone or in conjunction with any other provider enrollment requirements that currently exist in the state. However, if a state relies on self-attestation, it must annually review a statistically valid sample of physicians who have self-attested. The final rule does not provide higher payment 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. **This is generally consistent with the proposed rules and is supported by the College. The final rule expanded the number of Specialty Boards that qualify, and makes the attestation requirement for the state less burdensome.**
While ACP supports the alternative eligibility determination method based on the proportion of defined primary care services delivered by the physician, the College recommends that the 60 % criteria should be based on allowed charges rather than percent of billing codes—this would be consistent with the definition used under the Medicare Primary Care Bonus provision of the ACA	The rule maintains the same claims requirement as defined in the proposed rule that is based on the proportion of defined primary care services as opposed to the proportion of allowed charges. **The College supports the use of the delivery of a substantial**

Proposed Rule Comments by ACP	Final Rule with Details
and would be less likely to inappropriately exclude those physicians who truly provide primary care services, but are also required to provide a broad range of other services due to the limited availability of other clinicians in the area e.g. in rural and similar underserved areas.	**amount of defined primary care services as an alternative criterion to receive the increased payment, but continues to support the determination based on proportion of allowed charges rather than percent of claims.**
The College also commends CMS for making the increased payment available for those designated primary care services provided by a non-physician practitioner (e.g. Nurse Practitioner) if properly billed through a qualified, supervising physician. This will serve as further incentive for physician participation in the Medicaid program.	The rule allows the increased payment for primary care services furnished by nonphysician practitioners "by or under the personal supervision" of a physician who is one of the primary care specialty or subspecialty types designated in the regulation. If the state plan in 2009 reimbursed services provided by nonphysician practitioners under the supervision of a physician at a percentage of the physician fee schedule rate, that same practice must be continued in CYs 2013 and 2014 **This is consistent with the proposed rule and is supported by the College.**
The rules states 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 codes. The rule further specifies that Medicaid will also pay at the enhanced rate for codes in that range not currently paid for under Medicare and indicates four such service areas that are: • New Patient/Initial Comprehensive Preventive Medicine--codes 99381 through 99387; • Established Patient/Periodic Comprehensive Preventive Medicine—codes 99391 through 99397; • Counseling Risk Factor Reduction and Behavior Change	This rule requires state Medicaid agencies to reimburse at the applicable 2013 or 2014 Medicare rate for E&M codes 99201 through 99499 to the extent that those codes are covered by the approved Medicaid state plan or included in a managed care contract. This includes codes within the specified range not currently covered by Medicare e.g. (E&M Non Face-to-Face codes, Consultation Services codes). **The final rule is generally consistent with the proposed rule and is supported by the College. The College is particularly pleased with the inclusion of service codes in the defined range that are not currently paid for under Medicare**

Proposed Rule Comments by ACP	Final Rule with Details
Intervention—codes 99401 through 99404, 99408, 99409, 99411, 99412, 99420 and 99429; • E&M/Non Face-to-Face physician Service--codes 99441 through 99444.	
The College would like to point out that in addition to the four code sets above, there are additional E/M codes in the defined eligible range that Medicare does not currently pay for and should be eligible for the higher Medicaid payment. The College believes that these additional codes are all important for the delivery of effective care and their payment would increase the likelihood of physician participation in the program. These are: • Consultation Services (99241-99245 and 99251-99255) • Anticoagulant Management (99363 and 99364) • Medical Team Conference (99366-99368) • Care Plan Oversight (99339-99340 and 99374-99380) • Counseling Services (99401-99420)	See above
The College would also like to point out that in the past several years Medicare has been paying for a number of preventive, counseling and screening services through "g" codes rather than the related E/M service codes. Many of these codes derive from recommendations from the U.S. Preventive Services Task Force. The College recommends that these services be included as eligible under the provisions of this rule. A list and description of these services is available at http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/	The final rule limits the payment increases to the service codes specified in the proposed rule. Thus, it does not apply to "g" code services. **The College continues to believe the services recommended by the U.S. Preventive Services Task Force and designated as "g" codes are an important part of primary care and should be included as services eligible for the increase.**
The limitation of enhanced payment for only two years will serve as a barrier for participation by many of our members—even at these enhanced rates. In addition, survey research indicates that there are substantial administrative hassles connected with physician participation within the program—	The final rule requires that states collect and report to CMS data on the impact of the higher rates on physician participation. That data will assist Congress in determining whether or not to extend the provisions of this rule beyond the end of CY 2014. Relevant data is required as early as CY 2013.

Proposed Rule Comments by ACP	Final Rule with Details
these include onerous billing requirements, unnecessary paper work and delayed reimbursement. o CMS work with the states to facilitate timely data collection to determine the effects on the quality and efficiency of care being received under Medicaid with the implementation of these enhanced fees. The more evidence that can be obtained that this provision provides increased physician participation, improved care to beneficiaries and lower cost to the states, the more likely the states will cover this enhanced payment following the termination of this provision. We believe physicians would be more willing to participate if efforts were being made to increase the likelihood of these enhanced payments following 2014. In order to address these issues, ACP recommends that: o CMS work with the states to reduce the administrative hassles on physicians who choose to participate in the Medicaid program.	The final rule makes no mention of any efforts to reduce physician burdens in enrolling and participating within the Medicaid program. **The College supports the requirement of early data collection.** **The College is disappointed that the final rule did not address efforts to eliminate unnecessary administrative burdens related to enrollment or participation within the Medicaid (or CHIP) program.**
Additional Information on Final Rule Not Referred to in Comment Letter	
Economic Impact of Payments to Physicians for Primary Care Services	The overall economic impact of this final rule is an estimated $5.600 billion in CY 2013 and $5.745 billion in CY 2014 (in constant 2012 dollars). In CY 2013, the federal cost for Medicaid and CHIP is approximately $5.835 billion with $235 million in state savings. In CY 2014, the federal cost for Medicaid and CHIP is approximately $6.055 billion with $310 million in state savings.