FAQs on the Medicaid Payment Increase for Primary Care and Immunization Administration Services & Updates to the Vaccines for Children Program Regional Maximum Charges

What does the regulation do?

- For evaluation and management (E&M) codes 99201 – 99499 and vaccine administration codes 90460 – 90461 and 90471 – 90474 (or their successors), the Rule sets a floor of payment in the Medicaid system of 100% of the Medicare rate.
- In 2013 and 2014, state Medicaid programs must pay physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine for these codes at least at the Medicare rate in effect in CYs 2013 and 2014, or if higher the rate using the CY 2009 Medicare conversion factor and 2013 and 2014 RVUs.
- States will receive 100% federal funding for the difference between the increased rates and the Medicaid rates paid by the state as of July 1, 2009 (excluding incentive, bonus, and performance-based payments).
- Payment will reference the Medicare Physician Fee Schedule (MPFS) rate applicable to the site of service and the specific geographic location of the service or, at state option, the Medicare office setting rate adjusted for either the specific geographic location or the mean over all counties of the rate for each E&M code.
- The Rule applies to payments under the Children's Health Insurance Program (CHIP) plans only in states where CHIP is an expansion of the state's Medicaid program. The State will receive 100% federal matching funds for the difference between the rate in effect on July 1, 2009 and the rate in CYs 2013 and 2014.
- The Rule applies to primary care services paid on a fee-for-service basis as well as those paid by Medicaid managed care plans.
- The Centers for Medicare and Medicaid Services (CMS) and states are empowered to review managed care contracts to ensure that the payment increase requirements are met.
- The Final Rule also updates the Vaccines for Children (VFC) program regional maximum immunization administration fees, not updated since the VFC program was established in 1994.
- For vaccines provided under the VFC Program in CYs 2013 and 2014, the state Medicaid program must pay the lesser of the updated regional maximum administration fee or the Medicare fee schedule rate in CY 2013 or 2014 (or if higher, the rate using the 2009 Medicare conversion factor).

To which codes does the payment increase apply?

- Immunization Administration codes 90460, 90471, 90472, 90473 and 90474 or their successors.
- Healthcare Common Procedure Coding System (HCPCS) E&M CPT codes 99201 – 99499. These E&M codes include those that are not recognized for payment by Medicare but have published RVUs associated with them:
  - 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 99429; and
  - E&M/Non Face-to-Face physician Service: codes 99441 – 99444.
- Medicare sets and publishes RVUs for the above codes even though Medicare itself does not pay for the services. The rates for these non-paid Medicare services will be established using the Medicare conversion factor in effect in CYs 2013 and 2014 (or the CY 2009 conversion factor, if higher) and the RVUs recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) and published by CMS for CYs 2013 and 2014. This information will be made available through Medicaid.gov.
- For new codes added to the E&M range since 2009, states will receive 100% federal funding for the entire payment of these codes at the Medicare rates. However, states cannot add codes to their code set solely for the purpose of receiving 100% federal funding.

Which physicians are eligible for the payment increase?

- Physicians (MD's and DO's) with a primary specialty designation of family medicine, general internal medicine, and pediatric medicine are eligible to receive the Medicaid payment rate increase for the specified codes.
- Subspecialists that fall within these three primary specialty categories may also qualify.
- To qualify, pediatricians and eligible pediatric subspecialists must self-attest that they are either Board certified by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS), *or* that 60% of all of the Medicaid services they billed (during the most recently completed CY, or for newly eligible physicians, the prior month), or provided in a managed care environment, are for any of the eligible E&M and vaccine administration codes.[1]
- At the end of each year, the State Medicaid agency must review a statistically valid sample of physicians who received the higher payments to verify that they met the requirements.
- The increased payment also applies to services furnished by non-physician practitioners, such as nurse practitioners and physician assistants, working under the supervision of an eligible physician.
- This increased payment does not apply to Federally Qualified Health Centers or Rural Health Clinics as these sites are paid by Medicaid under a different structure.

[1] It is possible that a physician might maintain a particular qualifying Board certification (i.e. pediatric cardiology) but actually practices in a non-eligible specialty (i.e. pediatric surgery). This physician should not self-attest to eligibility for higher payment. Similarly, a physician Board certified in a non-eligible specialty (i.e. pediatric surgery) who actually practices in an eligible specialty (i.e. as a general pediatrician) could self-attest to eligibility with a supporting 60% billing claims history.

Qualifying Board Certified Pediatric Subspecialties:

American Board of Medical Specialties (ABMS)	
Pediatrics	Adolescent Medicine Child Abuse Pediatrics Developmental-Behavioral Pediatrics Hospice and Palliative Medicine Medical Toxicology Neonatal-Perinatal Medicine Neurodevelopmental Disabilities Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Pulmonology Pediatric Rheumatology Pediatric Transplant Hepatology Sleep Medicine Sports Medicine
American Osteopathic Association (AOA)	
Pediatrics	Adolescent and Young Adult Medicine Neonatology Pediatric Allergy/Immunology Pediatric Endocrinology Pediatric Pulmonology

Note: The ABPS does not certify subspecialists. Physicians who are Board-certified by the ABPS in Internal Medicine, Family Practice, or Family Medicine Obstetrics qualify for the higher payment. There is no ABPS Board certification specific to Pediatrics.

State Requirements

- States must submit a Medicaid state plan amendment (SPA) to reflect the increase in fee schedule payments in CYs 2013 and 2014. CMS has issued a SPA template for the purpose of expediting review and approval of the payment increase.
- The SPA must identify all eligible codes that will be paid at the Medicare rate in 2013 and 2014; all codes that were not paid under the state's Medicaid program as of July 1, 2009; and specify how the state will make the site of service and geographic location adjustments.
- States must submit the methodology they intend to use to identify the amount of the capitation payment to managed care plans attributable to increased provider rates no later than the end of the first quarter of CY 2013.
- Once attestation procedures are in place and eligible providers are identified, the state will make one or more supplemental payments for the difference between the amount paid and the increased rates due to those providers.
- States can impose reasonable requirements regarding self-attestation deadlines for purposes of retroactive payment. For example, a state could limit retroactive payments to the beginning of the month or quarter in which the self-attestation is submitted. The AAP has been working with CMS to ensure that no state imposes an unreasonable self-attestation deadline for retroactive payment.

Managed care and contract physicians

- After CMS approval of state-submitted, revised managed care contracts and rates, the managed care plans must direct the full amount of the increased payment to eligible providers.
- 100% federal funding is available for the portion of capitation rates attributable to the increased payments. CMS will implement the managed care requirements through a state-by-state review of managed care contracts and applicable procedures to ensure that the increase in payments is passed directly to the physician, regardless of whether a physician is salaried or receives a fee-for-service or capitated payment.
- All payments made in CY2013 prior to CMS approval of state methodology for calculating the primary care rate differential, certified rates, and managed care contract amendments will be re-adjudicated and the full amount of the increased payment will go to the eligible physician.

How does the regulation address vaccines?

- The Final Rule sets forth unequivocally that the VFC statute does not permit payment for each additional vaccine/toxoid component administered in a multi-component vaccine. This disallows payment for CPT code 90461 by Medicaid, meaning physicians participating in the VFC program can only bill for CPT code 90460 when administering a multi-component vaccine.
- The state must impute the payment that would have been made for code 90460 under the approved Medicaid state plan in effect on July 1, 2009 by using the payment rates for codes 90465 and 90471, weighted by service volume.

How does the regulation address regional maximum charges?

- The Rule increases payment of immunization administration fees under the VFC program to either the new 2013 and 2014 VFC regional maximum administration fees (the VFC "ceiling"), or if lower, the Medicare vaccine administration rates for those years (or, if higher, the rate using the 2009 conversion factor and the 2013 and 2014 RVUs). The 2013 Medicare vaccine administration fees were released on November 1, 2012.
- Because the VFC ceiling rates were issued on an interim basis in 1994 and have not been updated until now, they have been updated based on the Medicare Economic Index (MEI), which is a measure of medical practice cost inflation. The rates have increased by around 30% with variation depending on the state in question.
- A chart (reproduced below) is published in the Final Rule with each States' new regional maximum administration fee.

Regional Maximum Administration Fee by State		
State	Current regional maximum fee	Updated regional maximum fee
Alabama	$14.26	$19.79
Alaska	17.54	27.44
Arizona	15.43	21.33
Arkansas	13.30	19.54
California	17.55	26.03
Colorado	14.74	21.68
Connecticut	16.56	23.41
Delaware	16.55	22.07
District of Columbia	15.13	24.48
Florida	16.06	24.01
Georgia	14.81	21.93
Guam		23.11
Hawaii	15.71	23.11
Idaho	14.34	20.13
Illinois	16.79	23.87
Indiana	14.47	20.32
Iowa	14.58	19.68
Kansas	14.80	20.26
Kentucky	14.17	19.93
Louisiana	15.22	21.30
Maine	14.37	21.58
Maryland	15.49	23.28
Massachusetts	15.78	23.29
Michigan	16.75	23.03
Minnesota	14.69	21.22
Mississippi	13.92	19.79
Missouri	15.07	21.53
Montana	14.13	21.32
Nebraska	13.58	19.82
Nevada	16.13	22.57

New Hampshire	14.51	22.02
New Jersey	16.34	24.23
New Mexico	14.28	20.80
New York	17.85	25.10
North Carolina	13.71	20.45
North Dakota	13.90	20.99
Ohio	14.67	21.25
Oklahoma	13.89	19.58
Oregon	15.19	21.96
Pennsylvania	15.76	23.14
Puerto Rico	12.24	16.80
Rhode Island	14.93	22.69
South Carolina	13.62	20.16
South Dakota	13.56	20.73
Tennessee	13.70	20.00
Texas	14.85	22.06
Utah	14.52	20.72
Vermont	13.86	21.22
Virginia	14.71	21.24
Virgin Islands	15.09	21.81
Washington	15.60	23.44
West Virginia	14.49	19.85
Wisconsin	15.02	20.83
Wyoming	14.31	21.72

Please contact Robert Hall, Associate Director of the Washington, DC Office of the American Academy of Pediatrics, with any questions regarding the Final Rule. Mr. Hall can be reached at RHall@aap.org or 202-724-3301.