

**Primary Care Rate Increase  
Fast Facts  
November 2012**

**Overview:** Requires payment for primary care services provided by certain physicians to be at parity with at least the Medicare rates in effect in Calendar years 2013 & 2014 or if higher the rate that will be applicable using the CY 2009 Medicare conversion factor. Also updates vaccine rates, which have not been updated since the VFC program was established in 1994.

**Eligible Providers:**

- Board certified physicians 1
  - Family Medicine
  - General Internal Medicine
  - Pediatric Medicine
  - Or 60% of their Medicaid claims are for eligible E&M codes
- Physician sub specialists
  - Board certified in those specialties or;
    - Provide primary care within the overall scope of eligible categories.
- Advanced practice professionals practicing under the personal supervision of eligible physicians
  - Does not require billing under the physicians billing #. Physician must have professional responsibility for services provided
- FQHCs and RHCs do not qualify for the increase.

**Attestations:**

- May ask for documentation of Board certification.
- Audit of statistically valid sample of physicians is required.
- May delegate the audit to MCOs in managed care setting. Required to amend contract language.

**Managed Care:**

- Submit 2 methodologies that calculate the 2009 baseline rate and payment differential by March 31, 2013
  - If methodology is not approved before January 1, 2013. Clarification to CMS how retroactive payments will be implemented
- MCOs required by contract that eligible PCPs receive the increase. Required to:
  1. Demonstrate higher rate is passed on to PCPs.
  2. Specify documentation to substantiate enhanced payment is passed on.

**Eligible Codes:**

- E&M codes: 99201-99499. Vaccine administration codes: 90460, 90461, 90471, 90472, 90473, 90474

**Fee For Service**

- Rate increase payment can be:
  - Added on to existing rates or
  - Paid in minimum quarterly lump sum payments

**State Plan Amendment (SPA):**

- Sunset dates are permitted. Rates reverted to after December 31, 2014 must be described in SPA. Public notice must indicate higher payments will end as of that date.
- SPA template requires:
  - Site of service adjustments or Medicare rate applicable to office setting.
  - Medicare locality adjustments or statewide rate per code reflecting mean over all counties
  - Payments made as part of fee schedule or supplemental.
  - Codes, which will be paid, and codes that have been added to the fee schedule since 2009.

**Claiming FFP:**

- Cost claiming on 100% of the differential.
- CMS will provide states with reporting instructions

**Data Reporting:**

- Required to collect and report to CMS data on the impact of the higher rates on physician participation.
  - Timeline not clear within rule.