Affordable Care Act and Immunizations – Provisions Relating to Medicaid

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Overview

- Two Affordable Care Act provisions impact immunizations and the Medicaid program.
  - Primary Care Payment Increase (section 1202) provides increased payment for E&M services and vaccine administration for qualified providers
  - Section 4106 provides states a 1 percent Federal Medical Assistance Percentage (FMAP) increase on preventive services if they cover all USPSTF preventive services and all ACIP-recommended vaccines without cost-sharing.

Primary Care Payment Increase

- Requires that eligible primary care services be reimbursed at at least the Medicare rates in effect in calendar years 2013 and 2014 for services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine, or a related sub-specialty. The payment increase is for services provided through both fee-for-service and managed care delivery systems.

- States will receive 100 percent Federal financial participation for the difference between the Medicaid State plan payment amount as of July 1, 2009, and the Medicare rates in effect in CYs 2013 and 2014 for a set of Healthcare common Procedure Coding System (HCPCS) codes used for evaluation and management (E&M) services and for certain Current Procedural Terminology (CPT) codes associated with vaccine administration.

Primary Care Payment Increase - Qualified Providers

- In order to qualify, physicians must self-attest to a specialty designation of family medicine, general internal medicine, or pediatric medicine.

- The attestation has to be supported by either Board Certification in these areas or by a claims history that shows that 60 percent of codes billed in a prior period were for the eligible E&M codes.

- States will not have to verify each provider, but will have to review a statistically valid sample of physicians who claim eligibility every year.

Qualified Practitioners - continued

- Services provided by non-physician practitioners under the personal supervision of an eligible physician are eligible for the payment increase.

- Independently practicing non-physicians who are not associated with a physician are ineligible for higher payment.

- The increased payment is based on the assumption that a relationship exists in which the physician has professional oversight or responsibility for the services provided under his or her supervision.

Eligible Codes

- The payment increase is for the entire range of E&M codes including those associated with emergency department services and hospital and critical care services, as well as for the vaccine administration codes.

- Local codes are eligible for the payment increase if the state submits a crosswalk of those codes to the specified E&M codes.

Increased Vaccine Administration Payments - VFC

- The amount of the increased payment for vaccine administration differs for children and adults.
- For children under age 19, payment will be the lesser of the Vaccines for Children (VFC) regional maximum administration fee or the Medicare physician fee schedule rate.
- There is no payment for code 90461 which is for additional components in a combination vaccine. This is consistent with VFC policy.

Increased Vaccine Administration Payments – VFC, continued

- Because of the vaccine administration coding change in 2011, States also need to determine the 2009 rate. A formula for doing this was included in the Final Rule.
- However, if a state can identify what it paid for vaccine administration codes on July 1, 2009, states can use that rate and will not have to use the formula from the Final Rule.

Increased Vaccine Administration Payments – VFC, continued

- A number of states require providers to use the vaccine product code instead of the vaccine administration code in order to assist with reporting on quality measures.

- CMS originally stated that all states need to use the vaccine administration codes in order to receive the increased payments as they were specifically identified in the Affordable Care Act. After learning of the difficulty that this created for states, we changed our position and states can now continue to use the product codes as long as they provide a crosswalk in their SPA submission.

Increased Vaccine Administration Payments - Adults

- The increased payments for adult vaccine administration will be at the Medicare rate. (The “lesser of” policy only applies to VFC.)
- This includes vaccine administration payments for children aged 19 and 20 who receive the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program benefit but have aged out of the VFC program.

Updated Fee Schedule for the VFC Program

- The final rule also updates the maximum administration fees for the Vaccines for Children (VFC) program. That fee schedule had not previously been updated since the VFC program began in 1994.

- This updated fee schedule is what states should use when determining the lesser of amount for the increased primary care payment for vaccine administration for children.

- There are no other changes to the VFC program. States continue to have the flexibility to determine their state's regional maximum administration fee.

Technical Assistance

- CMS is committed to providing technical assistance to States and other stakeholders as this program is implemented.

- CMS has a contract with Deloitte to provide technical assistance to states. As part of this contract, Deloitte has developed a tool that assists states by providing the Medicare rates.

- We have posted Questions/Answers on the Medicaid.gov website, and will continue to do so. Any questions can be sent to CMCSPPACAquestions@cms.hhs.gov.

State Action

- State Medicaid programs have the lead in the implementation of this provision. This includes establishing a process that identifies qualified providers, determining the increased payment rates, and establishing a payment process .

- States are required to submit a state plan amendment (SPA) defining how they will implement this provision. CMS has developed and shared with states a template to assist with this.

- The SPA must be submitted by March 31, 2013. By submitting it by this date, the effective date will be the first day of the quarter submitted, which is January 1, 2013.

Evaluation

- There will be an evaluation of the impact of this provision by components within HHS. The details of this evaluation are being determined.

- In addition, states are required to submit to CMS information relating to participation by eligible physicians and utilization of the identified codes. CMS will provide further guidance on this requirement at a later date.

Section 4106

- Section 4106 of the Affordable Act gives states a 1 percent increase in their Federal Medical Assistance Percentage (FMAP) for preventive services if they cover all USPSTF Grade A/B recommended preventive services and all ACIP-recommended vaccines without cost-sharing.
- In the Medicaid program, preventive services for adults are optional services.

Section 4106 - continued

- CMS is finalizing guidance on this provision and expects that it will be released in the very near future.
- States will also have to submit a state plan amendment in order to receive this benefit.
- CMS recognizes that there is overlap between the services that will qualify for this FMAP increase for states and the primary care increase for providers, and will allow for this overlap.

Questions?