ChildNet
Medical Associates

GOVERNMENT RELATIONS UPDATE

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Tim Curley, Director of Community and Government Relations
559-353-8610 / tcurley@childrenscentralcal.org

Federal Budget for 2014

Over the last several months, Congress and the President issued competing budget proposals for federal fiscal year (FY) 2014, which begins October 1. In March, the U.S. House of Representatives and the U.S. Senate passed separate, non binding, budget proposals, each of which includes sizeable spending reductions in public health insurance programs, including Medicaid. The Senate budget includes $10 billion in Medicaid cuts over the next 10 years, while the House budget includes a whopping $756 billion in Medicaid cuts over the same time period. Annually, the federal government spends about $260 billion on Medicaid.

In April, President Obama weighed in with his own budget proposal, which includes $20 billion in Medicaid cuts over 10 years, plus a 66% reduction in funding for the Children's Hospital Graduate Medical Education Program for FY 2014.

Children's Hospital has been and will continue to work with its members of Congress to ensure that the final budget agreement protects and where possible enhances access to specialized pediatric care.

State Budget

In mid-May, Governor Brown will release his final budget proposal for the new state fiscal year beginning July 1, 2013. With voter approval of the Governor's income and sales tax initiative last November and encouraging news on 2012 state income tax returns, next year's budget should not be as hard on health care as previous years' budgets have been. Nevertheless, Children's Hospital will be fully engaged in the upcoming state budget discussions to ensure that access to specialized pediatric care is protected or enhanced where possible.

Primary Care Physician Reimbursement Increase

See pages 2-3.

Payments for Certain Primary Care Services
Health Care Reconciliation Act of 2010
HR 4872-24, Section 1202

The Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (House of Representatives) 4872-24, Section 1202, requires states to increase payments for certain primary care services furnished in 2013 and 2014 by physicians with a primary specialty designation of family medicine, general internal medicine or pediatric medicine (or a sub-specialty under one of these specialty designations) at a rate not less than 100 percent of the Medicare rate in effect during 2013 and 2014 or, if greater, the payment that would have been applicable in 2009. The Department of Health Care Services (DHCS) will receive 100 percent federal financial participation (FFP) for any additional increase in payments above the Medi-Cal rates that were in effect as of July 1, 2009, compared to the 2013 and 2014 Medicare rates.

Primary care services are defined in HR 4872-24, Section 1202 as:

- CPT-4 Evaluation and Management (E&M) codes 99201 through 99499
- Services related to immunization administration for vaccines and toxoids-procedure codes 90460, 90461, 90471, 90472, 90473, and 90474

Implementation
DHCS submitted a State Plan Amendment to the Centers for Medicare & Medicaid Services (CMS) on March 29, 2013, to request federal approval. DHCS anticipates receiving federal approval sometime in the summer of 2013, and is working with the DHCS Fiscal Intermediary (FI), Xerox State Health Care, LLC, to begin implementing the payment increase within the same time frame.

Upon federal approval and implementation, retroactive payments will be issued to eligible providers effective for dates of service on or after January 1, 2013. The payment increase is effective for dates of service on January 1, 2013, through December 31, 2014.

To qualify for enhanced payments, providers will be required to self-attest eligibility. DHCS is developing a website for providers to self-attest online. Additional self-attestation website instructions and technical guidance will be provided at a later date.

Eligibility
The enhanced payment applies to primary care services delivered in either a fee-for-service or managed care environment. For fee-for-service, the services must be provided by a physician enrolled in the Medi-Cal program. For managed care plan requirements, an All-Plan Letter referencing more specific detail will be released soon.

Eligible providers must self-attest that they are:

Eligible in one of the following required, covered specialties: family medicine, general internal medicine, and pediatric medicine or a designated subspecialty within those specialties recognized by the American Board of Physician Specialties (ABPS), the American Osteopathic Association (AOA) or the American Board of Medical Specialties (ABMS); and

- Are Board certified in one of the covered specialties or subspecialty, or
- Certify that 60 percent of their Medi-Cal claims for the prior year were for the E&M and vaccine codes specified in the regulation. Newly-enrolled providers may attest based on the most recent month's claim history.

Higher payment will also be made for primary care services rendered by non-medical practitioners working under the direct supervision of a qualifying physician. The physician assumes professional responsibility for the services provided by the practitioners under his or her supervision. Advanced

practice clinicians providing services within their state's scope of practice under the supervision of an eligible physician will be eligible for higher payment as well.

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) are not eligible for the enhanced payments.

Rendering Providers
Rendering providers that are part of a physician group, hospital, clinic or other provider type are eligible for the enhanced payment if:

- The physician group, hospital, clinic, or other provider type is reimbursed in accordance with the physician fee schedule (does not apply to any services within RHCs or FQHCs that may be reimbursed according to the physician fee schedule).
- The physician working in a physician group, hospital or clinic is an eligible physician and has self-attested.
- The increase is passed on entirely to the physician who rendered the services and has self-attested.
- The rendering physician is an enrolled Medi-Cal provider and the physician's Medi-Cal provider number is listed in the rendering provider portion of the claim form.

Payment Increase
CMS provided several payment enhancement options for the E&M and vaccine administration codes; DHCS has chosen to use Medicare Rate for Office Site of Service with All Geographic Adjustments as the payment method. All existing Medi-Cal timely claims submissions and payment requirements apply. Upon implementation, eligible E&M and vaccine administration codes and enhanced rates will be available on the Medi-Cal Rates page of the Medi-Cal website.

Local Code Crosswalks
Local codes qualifying for the enhanced payments are being crosswalked to equivalent E&M and vaccine administration codes. Upon federal approval, further claims submission instructions and guidance will be available to providers through *Medi-Cal Update* provider bulletins on the Medi-Cal website and a posting on the DHCS website. For most local codes, there is one equivalent E&M code, and providers will not be required to change billing practices to receive enhanced payment.

However, individual local codes used primarily to bill neonatal and pediatric intensive care services may have many different equivalent E&M codes. Providers should continue to bill the local codes, but should make note of the equivalent E&M codes to facilitate future payment adjustment to the Medicare rate for the appropriate E&M code for each service rendered.

Annual Reviews
States are required to conduct annual reviews of physician self-attestations to ensure compliance with CMS requirements under PPACA.