

How Dual Eligibles Can Benefit From Medicaid PCP Payment Increases

Starting January 1, 2013, state Medicaid programs are now required to pay certain physicians at rates that are no lower than Medicare rates. It is important for advocates to understand this change in order help clients access providers, advocate for more Medicaid providers and other important systemic fixes at the state level.

A federal match will cover 100% of the added costs. This change, which implements a provision of the Affordable Care Act, codified at 42 USC 1396a(a)(13)(C), affects provision of primary care services by primary care physicians, internists, and nurse practitioners and physician assistants working under the direction of a physician.

The change, which covers a broad range of services and a number of important subspecialties, offers the promise of a significant increase in access to needed providers. This analysis discusses the specific impact of the change on dual eligibles, including those who are Qualified Medicare Beneficiaries but not entitled to full Medicaid benefits (QMB-only).

What does this mean for a physician who sees a dual eligible individual as a patient?

Prior to January 1, a physician treating a dual eligible would receive 80 percent of the Medicare-approved amount for the service. Medicaid had an obligation to pay the remainder but only up to the state's Medicaid rate for the same service. In practice this meant that many providers received nothing from Medicaid. This shortfall has meant that many providers who treat Medicare patients have refused to accept dual eligibles as patients. Though balance billing of these beneficiaries is prohibited, advocates report cases where individuals, desperate to get access to needed services, agree to pay the prohibited charges.

With the new requirement, state Medicaid programs must pay family physicians, internists and pediatricians full Medicare rates for covered services, which are defined as all evaluation and management (E&M) codes, specifically codes 99201 through 99449 in the Healthcare Common Procedure Coding System (HCPCS). Vaccine administration charges are also included. Thus, for those providers and those services, Medicaid must pay the full remaining 20 percent of the Medicare approved amount.

What specialties are included?

The ACA required that the payment rules apply to a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. In its regulations and recent important sub-regulatory guidance, CMS interpreted the provision to include all subspecialties of those categories as set out by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), American Osteopathic Association (AOA) or American Board of Physician Specialties (ABPS).

Of these categories, the ones that may be of most interest to seniors and persons with disabilities who make up the dual eligible population are the subspecialties of internal medicine listed by the ABMA, the largest certifying organization:

Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Geriatric Medicine; Hematology; Hospice and Palliative Medicine; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Sleep Medicine; Sports Medicine; Transplant Hepatology.

A full list of appropriate certifications and certifying entities is available [here](#).

Coverage is also available for physicians who are not board certified in the covered categories but who can attest that at least 60% of their billings over the prior year were in the covered billing codes. Nurse practitioners and physician assistants also are covered if working under the supervision of a physician.

How will the physician get paid?

That depends:

If the physician is enrolled in Medicaid: In most cases, payment should be automatic. After paying the 80 percent of the Medicare approved amount, the Medicare billing contractor should forward to the bill to Medicaid, which should pay the remainder.

If the physician is not enrolled in Medicaid: CMS requires states to have procedures to process claims from Medicare-enrolled providers who are not enrolled in Medicaid. CMS has encouraged states to develop simple processes but, in many states, these procedures are almost as cumbersome as those for Medicaid physicians. Often, they also are not easily found on state websites and not well understood even within the state Medicaid agencies. These complexities have mattered little because, with low

state Medicaid reimbursement rates, physicians rarely bothered to use the process. However, they may act as barriers to the promise of increased physician access for dual eligibles.

If the dual eligible is enrolled in Medicaid or Medicare managed care: Physicians who work in managed care environments also are covered by the changes. Medicaid managed care plans are required to pay physicians consistent with the higher rate. If these plans use capitation or other alternate formulas, they must adopt methodologies approved by the state and CMS as consistent with the new rules. Physicians in Medicare managed care serving dual eligibles also are covered, though the mechanism by which they receive the Medicaid portion of their payment may vary depending on the state contractual relationship, if any, with the Medicare plan.

How does this affect balance billing protections?

Providers may only bill beneficiaries the state Medicaid copayment, if any. All [prohibitions on balance billing](#) remain in place. Because more providers will be able to receive Medicare rates, it is hoped that current problems with balance billing will be reduced.

How does the change affect QMB-onlys?

Applicable physician services provided to individuals who only qualify for the Qualified Medicare Beneficiary program (where Medicaid pays Medicare premiums and cost sharing but does not provide any other benefits) are covered by the new provisions.

Is this a permanent change?

No. The ACA requirements and the federal match last only through December 31, 2014. Additional legislation would be needed to continue the requirement.

What can advocates do?

- Understand the changes so you can help your clients with access to providers.
- Urge your state to undertake a campaign to enroll more Medicaid providers, particularly in the affected specialties. Help to get the word out to providers. Urge your state to simplify provider enrollment paperwork and also to ensure prompt provider payments.
- Find out the process your state uses for paying Medicaid claims from Medicare providers who are not enrolled in Medicaid. Work with your state to make the process transparent and easier for providers to use.

What resources are available?

CMS published a final rule: [77 Fed. Reg 66670](#) (Nov. 6, 2012) and two [factsheets](#).

Kaiser Family Foundation has issued two briefs, a [primer on the payment increase](#), and a [survey of changes in fees by state](#).

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