Expiring Payment Policies Could Mean Cuts to Primary Care and Other Internists' Services

2014 Leadership Day on Capitol Hill

Background

Where Things Stand

The federal government enacted into law two critical programs in 2010 to increase payment levels temporarily for primary care services under Medicare and Medicaid. Unfortunately, both programs will soon expire, which not only puts access to primary care services in jeopardy for so many Medicare and Medicaid beneficiaries but it could also mean significant payment cuts for physicians.

Of most immediate concern to ACP is the Medicaid Pay Comparability program, which ensures that Medicaid payments for primary care services will be no less than comparable Medicare rates for calendars years 2013 and 2014. Internal Medicine (including internal medicine subspecialists), pediatrics and its medical subspecialties, and family medicine are the specialties that are eligible for this program. This program is set to expire at the end of the year, at a time when so many states are choosing to expand their Medicaid programs, which only increases the demand for primary care physicians treating Medicaid patients in those states The enhanced Medicaid payments serve as incentives for eligible physicians to maintain or increase their Medicaid patient population in all states, whether or not a given state has elected to expand its Medicaid program. If Congress does not extend the program, internists in all but a few states will see deep cuts in Medicaid payments on January 1, as much as 60 cents on the dollar in some states! A top priority for ACP in 2014 is to urge Congress to extend this program for at least two years beyond 2014.

Another program benefitting primary care, this time under Medicare, will expire in 2015 if Congress does not step in to reauthorize the program. The Primary Care Incentive Program (PCIP) begins to address inequities in payments for primary care by providing a 10 percent bonus payment, in addition to the usual Medicare fee schedule amount, for designated primary care services provided by internists, family physicians, geriatricians and pediatricians, provided that 60 percent of the total billings of a physician in an eligible specialty are for the designated primary care services. The bonus program took effect on January 1, 2011 and will continue through 2015. While not in immediate danger of expiring or losing federal funding, the PCIP is also a critical component in what ACP views as an on-going effort to address disparities in payments that are major barriers to physicians entering and remaining in primary care specialties. Come 2016, the expiration of this program will again translate into deep cuts for physicians providing primary care services. ACP wants to see Congress reauthorize this program beyond 2015. However, we do not intend to aggressively advocate for extension this year because we recognize that Congress, in this difficult budget environment and in an election year, will not realistically view this as a priority at this time.

Our advocacy efforts to extend the Medicaid Pay Comparability program will be especially important this year and we are mobilizing a coalition effort behind it. Like any federal program that needs reauthorization, the Medicaid Pay Comparability program will encounter scrutiny by members of Congress about its effectiveness, its budget impact, and the soundness of its mission. The background information below is designed to help Leadership Day attendees understand these issues in the current political environment and we are working to provide you with Medicaid state-specific information that can bolster our message with lawmakers.

Background

The Medicaid Pay Comparability Program

The Medicaid Pay Comparability program will expire at the end of 2014 unless Congress intervenes to extend it. It was signed into law in 2010, as part of the Affordable Care Act (ACA), and was designed to increase Medicaid payment for primary care services to 100 percent of Medicare rates in 2013 and in 2014. Under current law, primary care services are defined as all evaluation and management services and vaccine administration services furnished by primary care physicians, i.e., general internists, pediatricians, and family physicians. It also provides for higher payment for subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American

Osteopathic Association and the American Board of Physician Specialties. Physicians qualifying for this enhanced payment by meeting the above qualifications must formally "attest" that they provide primary care services and meet one of the required specialty designations through a procedure defined by the Medicaid Director of their state. Physicians who are in those designated specialties but not board certified (are Board eligible) can also qualify if at least 60 percent of the codes billed by the physician for all of CY 2012 are for the E&M codes and vaccine administration codes specified in this regulation.

The Benefit to Physicians Providing Primary Care:

The increase applies to both fee-for-service and managed care Medicaid plans. The positive financial impact for physicians treating Medicaid patients is significant as Medicaid in most states pays primary care physicians at rates that are well below Medicare (and private insurance). In 2012, before this provision of law took effect, average Medicaid payment rates for primary care services were 58 percent of Medicare rates. A state-by-state accounting of Medicaid-to-Medicare payment ratios can be found here. We encourage Leadership Day attendees to examine these state ratios closely because lawmakers will likely be astounded at just how little Medicaid pays physicians compared to Medicare.

The policy of increasing Medicaid payment rates to no less than the comparable Medicare payments is based on well-established research that shows that low Medicaid payment levels in many states is associated with fewer physicians accepting large number of Medicaid patients into their practices, resulting in reduced access to persons covered under Medicaid:

- Decker SL. In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Raising Fees May Help. *Health Aff.* 2012;31(8);1673-1679. Accessed at http://content.healthaffairs.org/content/31/8/1673.abstract
- Shen and Zuckerman: The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries. http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2005.00382.x/abstract

In April 2014, ACP conducted a survey of a representative sample of its members who spend the majority of their professional time engaged in direct patient care. It found that 46 percent of the respondents who indicated they had enrolled in the Medicaid Pay Comparability program via their State Medicaid program would accept fewer Medicaid patients in 2015 (40 percent) or drop out of Medicaid entirely in 2015 (6 percent) if the Medicaid Pay Comparability program were allowed to expire on December 31, 2014.

Medicaid Expansion and the Need for Primary Care:

Medicaid currently provides coverage for more than 50 million Americans, including more than 20 million nonelderly adults. Under the ACA, states will have federal support beginning in 2014 to expand their Medicaid programs to include all adults living at up to 138 percent of the federal poverty level. In 2012, the United States Supreme Court upheld the Medicaid expansion provision but found that the penalty to states for not participating in the Medicaid expansion (loss of the federal government funding for the existing Medicaid program) was unconstitutionally coercive. Therefore, the Supreme Court gave states the option to expand their Medicaid program without the threat of a reduction in federal funding. If implemented by states as now expected by the Congressional Budget Office after the Supreme Court ruling regarding the ACA in June 2012, Medicaid expansion is projected to add more than 10 million individuals to the Medicaid population.

The Medicaid Pay Comparability program was included in the ACA because primary care physicians, including internal medicine subspecialists who provide primary care, will be particularly affected by the Medicaid expansion because millions of new patients will enter the health care system and many will have complex health care needs. Primary care physicians and subspecialists are not required to participate in Medicaid, and many practices do not accept Medicaid patients because reimbursement rates are relatively low and the administrative barriers are significant. Further, people who are currently eligible for Medicaid, but not enrolled, will likely enroll in Medicaid coverage to comply with the individual mandate included as part of the ACA, adding more beneficiaries to the program. Many of these new Medicaid patients will be adults who seek care from internists. These increased-payment rates apply to all states; independent of the state's decision regarding participation in the Medicaid expansion opportunity provided through the ACA.

Program Implementation Difficulties:

While the Medicaid Pay Comparability program became effective in January of 2013, its rollout went more slowly than expected, hampered by delays at the state level. The rules required that states amend their Medicaid plans to include this program and then submit those amendments for approval to the Centers for Medicare and Medicaid Services (CMS). Many states did not turn in these plan changes for federal approval, even though they were due by the end of March 2013.

ACP voiced concerns about problems with the roll-out, and provided extensive resources to ACP members along the way. Until the states submitted their amended Medicaid plans to CMS, and received subsequent approval, the payment increases did not flow to physicians. In addition, under the federal rules, physicians must "attest" to the states that they meet the necessary requirements to receive the Medicaid payment increase. Each state is different as to the attestation period, and the time period they gave physicians to attest varied. If a physician did not attest in time, he or she did not get paid.

These difficulties with the roll-out have made it very challenging to assess the overall impact to date of the Medicaid Pay Comparability Program on patient access to care, health outcomes, and physician satisfaction. Equally frustrating is the fact that this program is set to expire when it has not been operational long enough to accurately assess its true effectiveness.

ACP Advocacy**:**

ACP has been a champion of the Medicaid Pay Comparability program, stemming back to the earliest days before the ACA became law. A top priority for ACP is to extend this program, for at least two more years, although we would prefer the longest possible extension, and ideally, permanent reauthorization. Furthermore, a coalition including ACP, the American Academy of Family Physicians, the American Osteopathic Association, the American Pediatric Association, American Congress of Obstetrics and Gynecology, and others has mobilized behind this effort and we are developing a multi-pronged approach that will involve direct face-to-face advocacy with members of Congress, joint letters to lawmakers, and identifying key lawmakers willing to introduce legislation to extend the program. (Although ob-gyn physicians are not currently eligible for the Medicaid Pay Comparability program, ACP supports adding them as a designated eligible specialty as part of a bill to extend the program because ob-gyn physicians see a large number of Medicaid patients and for many women, are their only source of primary care services. As envisioned, ob-gyn physicians would qualify if at least 60 percent of the codes billed by the physician are for the E&M codes and vaccine administration codes specified in the program, as explained below).

ACP believes that extending these Medicaid rates at least through 2016 would demonstrate that it is effective in improving access to physician services, both for persons enrolled in the existing Medicaid program and persons who may become newly eligible for Medicaid in states that choose to accept the federal dollars to expand Medicaid. The extension is particularly important because its slow start up—with many states only now beginning to pay at the higher Medicare rates—combined with a lack of assurance that it will be extended beyond 2014 has not allowed an adequate enough time to demonstrate the program's effectiveness in improving access.

As noted above, ACP is also on record as including in the statute physicians practicing obstetrics and gynecology as qualified specialties, subject to the current eligibility requirement that at least 60 percent of their Medicaid billings are the primary care services as defined by the authorizing legislation, for the purposes of qualifying for the Medicaid primary care increases. For many women, an ob-gyn is the only physician they see regularly during their reproductive years and the only point of entry into the health care system. As of 2010, Medicaid programs in 30 states and the District of Columbia recognized ob-gyns as primary care providers in their managed care organizations. With nearly half of births in the United States now financed by Medicaid, inclusion of ob-gyns will improve the continuity of care, particularly for those women who were previously on Medicaid for pregnancy-related services.

It must be noted that there is a cost associated with extending the program which means, in this tight fiscal environment, Congress will insist on finding a way to pay for it. While that is a challenge, it will not deter us from making the best argument possible in favor of extending this program. In calendar year (CY) 2013, the federal cost of this program for

Medicaid and the Children's Health Insurance Program (CHIP) was approximately $5.835 billion with $235 million in state savings. In CY 2014, the federal cost for Medicaid and CHIP is approximately $6.055 billion with $310 million in state savings. In addition, there continue to be partisan differences over the merits of this program, namely because many Republicans question the usefulness of the very Medicaid program itself, and continue to seek avenues to turn Medicaid into a block grant program to reduce costs borne by the federal government.

Primary Care Incentive Program (PCIP)

This program begins to address inequities in payments for primary care by providing a 10 percent bonus payment, in addition to the usual Medicare fee schedule amount, for designated primary care services provided by self-designated internists, family physicians, geriatricians and pediatricians. (Physicians who self-designate in an internal medicine subspecialty are not eligible.) In order to qualify for the bonus, at least 60 percent of Medicare allowed charges of these physicians must consist of the designated primary care services: office, nursing facility, domiciliary, and home services. The program was implemented in January 2011 and will continue through 2015. Mandatory funds have been provided for this program, which does not appear to be in any immediate danger of being repealed or defunded by Congress, ACP continues to advocate for its preservation and for its extension beyond 2015.

CMS has determined that the 10 percent bonus is based on the amount "actually paid" to the physician for the designated service –with co-payments and deductibles excluded from the bonus calculation. Based on this "actual payment" methodology, the typical yearly payment for a qualified primary care physician is approximately $8,000 for the bonus year. Payments are made on a quarterly basis. Eligibility for the bonus is determined at the individual physician level. Multiple general internists in the same group practice can receive the bonus. The determination as to which physicians qualify is based on the revenue associated with each individual physician during the prior assessment period. Physicians do not have to register for this program. Medicare automatically determines eligible physicians based upon claims.

ACP applauded Congress for enacting this program back in 2010 because in the context of overall Medicare reform, which includes the need for permanent repeal of the Sustainable Growth Rate (SGR) physician payment formula, the Medicare bonus is a positive step forward in addressing disparities in payments that are major barriers to physicians entering and remaining in primary care specialties.

This program is a priority for ACP but we will not actively push for extension of the Medicare bonus at this time because Congress, sadly, tends to only seriously engage on issues that have a compelling degree of "immediacy" to them. Since this program does not expire until the end of 2015, and because it is an election year, lawmakers will likely not consider it a priority. Leadership Day attendees still need to be aware of the importance of this program as part of our on-going efforts to increase access to primary care services in the longer term.

For more information on ACP's positions on payment and delivery system reforms, please visit the Advocacy section of ACP Online, http://www.acponline.org/advocacy/where_we_stand/physician_payment/.