REPORT TO THE LEGISLATURE

Pediatric Primary Care Provider Reimbursement

Engrossed Substitute House Bill 1109; Section 1111(1)(ddd);
Chapter 415; Laws of 2019
November 1, 2019

Washington State Health Care Authority

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Legislative Reference

The Health Care Authority (HCA) submits this report pursuant to the 2019-2021 legislative budget proviso at Section 1111(1)(ddd), which states the following:

> $5,825,000 of the general fund—state appropriation for fiscal year 2019 and $8,019,000 of the general fund—federal appropriation are provided solely for an increase in primary care provider rates for pediatric care services that are currently reimbursed solely at the existing medical assistance rates that are applicable for the child's medical assistance eligibility group. These amounts are the maximum that the authority may spend for this purpose. The authority must pursue a state plan amendment to increase pediatric primary care provider and pediatric vaccine rates through state directed payments through a permissible payment model. The codes considered for these increases should follow those that were used under the temporary increase provided in calendar years 2013 and 2014 as outlined in section 1202 of the affordable care act. Both physician and nonphysician practitioners are eligible for these increases and are not required to attest. Increases are based upon eligible codes.
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> *The authority must provide a report to the governor and appropriate committees of the legislature by November 1, 2019, detailing how the amounts provided in this subsection were used, what percentage increase was provided for pediatric primary care provider evaluation and management rates, what percentage increase was provided for pediatric vaccine rates, how utilization has changed within each category, and how these rate increases have impacted access to care.*

The short period of time between the budget assignment and implementation has not allowed a robust evaluation period. The initial snapshot of the evaluation and management (E&M) codes and vaccine codes identified a potential decrease in utilization of services corresponding with a reduction in the population of children. Additional analysis of a full two year claims cycle would identify more complete patterns. The HCA is continuing to explore various reimbursement options with pediatric providers.

Although we understand it would be ideal for HCA to provide a specific rate increase percentage achieved with the addition of these funds, the variation between the FFS and MC rates and reimbursement methods in place prior to the addition of the funding make it extremely difficult to do so. Many of the PCPs that contract with our MCOs are reimbursed on a capitated basis rather than for each individual service they provide. This complexity prohibits us from capturing a distinct rate increase amount by service with the addition of these funds.

Background

Section 1202 of the Affordable Care Act amended section 1902(a)(13) of the Social Security Act to require payment for certain evaluation and management (E & M) services and immunization administration services furnished in calendar years 2013 and 2014 by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the Medicare payment rate. In the case of primary care services provided under Washington Apple Health (Medicaid) managed care plans for 2013 and 2014, the payment rates were adjusted to be consistent with the equivalent fee for service Medicare rate. After the two year period in which the heightened rates were available to providers, this provision expired and rates lowered to the previous levels.

This proviso explored how to restore this heightened payment level for primary care, or make other more targeted changes.

Analysis for this report is limited to the capabilities and time of existing HCA staff in both clinical and finance divisions, since no additional resources were provided for the development of this specific report. HCA determined an in depth review of primary care would be a useful in understanding the total picture, and the Chief Medical Officer has convened a Primary Care Summit and a more comprehensive work group about primary care in Washington State. Additionally, HCA is working with the state Pediatric Academy to explore various reimbursement methodology options specific to pediatric care. HCA aims to have outcomes and recommendations available for the 2021-2023 legislative biennial budget.

How the amounts provided in this proviso were used, what percentage increase was provided for pediatric primary care provider evaluation and management [E&M] rates, and what percentage increase was provided for pediatric vaccine rates

Rates for the specified E&M and vaccines codes were modeled separately, based on the capped budget authorized for these services. The enhanced rates started October 1, 2018, and included a 9.5 percent increase for E&M which increased the rates anywhere from $2.29 - $50.18 per claim. Vaccine administrative codes increased by 74 percent, which increased the rate by $8.89 for the first vaccine and $5.54 for any subsequent vaccines during the same visit. The administrative fee for vaccines supplied by the Vaccine for Children Program increased 173 percent from $5.96 to $16.27 per vaccine.

How utilization has changed within each category, and how these rate increases have impacted access to care

HCA analyzed fee-for-service paid claims and managed care encounters with a qualifying E&M or vaccination procedure code to determine the impact of the increase in payment for these specific services. HCA used six months of data before and after the rate increase to assess the change in utilization (number) of these two categories of services, and to assess the change in access to these services. HCA measured the impact on access through the difference in the number of clients served and the number of providers who rendered a qualifying service. To mitigate seasonal variation, HCA compared data with dates of service between October 2017 and March 2018 against that with dates of service between October 2018 and March 2019. This six month evaluation period is too short of a time frame to draw any conclusions about the impact this reimbursement increase had on the delivery and access to services. A longer evaluation period, at least 2 years, would be required to reach data driven, evidence-based conclusions to allow the full claims period to run out and ensure data can be drawn from paid claims. (For example, a two year cycle would allow one calendar year or twelve months of claims, with the eighteen month allowed for claims runout, and then an additional six months to complete analysis.)

The initial partial analysis found the following regarding the impact on the utilization of these services:

- The number of total E&M codes billed, which represents a qualifying face-to-face visit, decreased 6 percent, changing from 1,669,645 to 1,568,453 reported visits; and
- The number of total vaccinations administered slightly decreased by 1 percent, a change from 625,288 vaccinations administered to 621,012.

However, during this reporting period, the number of children ages 0-20 years in the Apple Health case load dropped by 75,000 (1.4 percent). The majority of this reduction (45,000) was in the 0 to 6 age group. This is notable because this is the age when children receive the most E&M and vaccination services. Therefore, this change in caseload numbers probably contributed to the decrease in utilization of E&M visit codes and vaccinations administered.

The analysis also found the following regarding the impact on access to these services:

- The number of patients who had a service for which an E&M visit code was billed, dropped slightly by 4.5 percent - from 579,368 clients served with this service to 553,119;
- The number of patients who received a vaccination, increased 10 percent, from 203,394 to 224,400 unique clients served;
- The number of unique servicing providers increased by 3 percent, from 18,478 to 19,060;
- The number of servicing providers administering vaccines increased 2 percent from 6,215 to 6,326.

The decrease in children in the caseload probably contributed to the 4.5 percent drop in the number of clients who received a qualifying service.

Conclusion

It is difficult to assess the impact that this rate increase made on E&M and vaccination services in this short reporting period. The analysis appears to indicate the rate increase may have contributed to increasing the number of servicing providers who provide these qualifying services to Apple Health clients. However, a longer evaluation period would be required to validate this conclusion.

While the utilization of E&M and vaccination services did not seem positively impacted, it is difficult to conclude what effect the rate increase may have had if the number of children in the caseload remained a bit more stable, and if this was a sufficient enough rate increase to stimulate better utilization of these services. The correlating decrease in the number of children in the caseload masks the opportunity to reach any compelling conclusions about how utilization was impacted. A longer evaluation period would be required to further assess the impact on the utilization of these services.