

# Medicaid Primary Care Rate Increase: Next Steps for State Implementation

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On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) released final regulations on a provision of the Affordable Care Act (ACA) requiring Medicaid agencies to increase primary care reimbursement to parity with Medicare rates in 2013 and 2014. This provision infuses \$11.4 billion into Medicaid primary care and is 100 percent funded by the federal government through an enhanced federal financial participation (FFP) rate.<sup>1</sup>

This rate increase can significantly bolster the primary care delivery system, potentially increasing access for current and new Medicaid beneficiaries and reducing unnecessary visits to the emergency department.<sup>2</sup> Improving access to primary care is essential as states prepare to serve the up to 15 million Americans who will become eligible for Medicaid in 2014 through health reform.<sup>3</sup>

With the release of this final rule, states can proceed with implementation of the rate increase. Although it appears straight-forward, the final rule grants states a fair amount of discretion in implementing some of the more complex aspects of the provision (e.g., as it relates to implementation in managed care environments), and there are significant operational issues that states must consider. At the same time, states are immersed in many other complex requirements of health reform. Since this provision goes live in January 2013, states must act quickly and should expect to devote a significant amount of resources to develop the methodologies, contract amendments, operational plans, and State Plan Amendments (SPA) required to implement the rule successfully.

This brief reviews the final regulatory language for this provision and highlights key considerations and operational steps for states. It is the fourth in a series of papers that the Center for Health Care Strategies (CHCS) is producing to help states translate CMS guidance and implement the payment increase.<sup>4,5,6</sup>

## IN BRIEF

With coverage expansion under the Affordable Care Act (ACA), Medicaid is expected to serve up to 80 million Americans by 2019. Ensuring sufficient provider participation is a key concern for states and the federal government as the Medicaid population expands. The Centers for Medicare & Medicaid Services (CMS) released final regulations on November 1, 2012 regarding a Medicaid primary care rate increase to Medicare levels for 2013 and 2014 – a provision that is intended to encourage greater provider participation in Medicaid. This technical assistance brief reviews the final regulatory language and identifies key questions and operational steps states should consider in implementing this provision.

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## Background

With coverage expansion under the ACA, Medicaid is expected to serve up to 80 million Americans by 2019. The shortage of primary care providers (PCPs), however, is particularly acute within Medicaid, where a declining number of primary care physicians are accepting Medicaid patients.<sup>7</sup> This decline is due in part to inadequate reimbursement, which is cited regularly by physicians as a disincentive to participate in Medicaid.<sup>8</sup> Medicaid generally pays PCPs lower than Medicare or commercial payers – in 2008, Medicaid fee-for-service (FFS) rates for primary care averaged 66 percent of Medicare rates.<sup>9</sup>

The benefits, however, for increased access to primary care services are clear. Primary care is linked to improved health outcomes for a majority of conditions, including cancer, heart disease, stroke, and infant mortality.<sup>10</sup>

If the Medicaid PCP rate increase induces PCPs to accept more Medicaid beneficiaries, then this provision can potentially reduce the likelihood that beneficiaries with certain chronic conditions visit a hospital emergency department instead of a physician's office.<sup>11</sup> Research using Medicare data suggests that increases in primary care rates can both improve access and reduce costs over the long-term.<sup>12</sup> Given renewed interest in care models that elevate the role of the primary care team to improve patient health, it is critical to strengthen the Medicaid primary care system.

With the primary care rate increase, the ACA provides states with an important tool to strengthen the primary care network for both existing and new beneficiaries. In preparing for and implementing the rate increase, states should consider the following issues:

1. Identifying eligible providers;
2. Identifying the primary care services covered;
3. Understanding baseline primary care rates for fee-for-service as of July 1, 2009;
4. Adjusting the rates for eligible primary care services within fee-for-service;
5. Implementing the rate increase in managed care;

6. Developing a SPA to reflect the fee schedule increases for eligible providers;
7. Calculating and reporting FFP; and
8. Measuring and enhancing the payment increase's impact on access to care.

## 1. Identifying Eligible Providers

The final regulatory language takes a broad approach in identifying eligible PCPs. Physicians qualify if (1) they are board-certified in family medicine, general internal medicine, and/or pediatric medicine, or a subspecialty related to those specialties, or (2) 60 percent of Medicaid services they bill are for the eligible Evaluation & Management (E&M) or vaccination administration codes. Physicians in these specialties and subspecialties must be board certified by the American Board of Medical Specialties (ABMS),<sup>13</sup> the American Osteopathic Association (AOA),<sup>14</sup> or the American Board of Physician Specialties (ABPS).<sup>15</sup> For example, a pediatric nephrologist board-certified by ABMS who provides primary care services would be eligible. It is worth noting that out-of-network and out-of-state providers are covered by this rule, if they meet the eligibility criteria.

### Timing for Implementation

The final rule for this provision was released just two months before implementation in January 2013. The final rule makes clear, however, that states have more time to implement this provision. States have until March 31, 2013 to submit a SPA with an effective date of January 1, 2013 and their managed care contract amendments. Given this CMS approval timeline, the regulations also provide states with the flexibility to pay PCPs retrospectively and re-adjudicate claims made before approval is finalized. Alternatively, states can pay providers prospectively; including, for example, some type of risk sharing that incorporates retrospective reconciliation to the documented expenditures.

The rule also indicates that, as long as states adhere to timely claims submission and payment requirements, 100 percent FFP will be available for all eligible services provided between January 1, 2013 and December 31, 2014. However, states will not be eligible for enhanced FFP until their SPA is approved.

CMS requires that eligible PCPs self-attest that they are either board certified in one of the allowed specialties or subspecialties, or that 60 percent of Medicaid services they bill, or provide in a managed care setting, are for allowed E&M and vaccine administration codes. Though states are not required to verify providers' self-attestation, they will be required to engage in an annual review of a "statistically valid sample of physicians" who have self-attested to determine that they are eligible PCPs according to the conditions noted. For services provided through a managed care delivery system, states must work with health plans to ensure that this verification is completed.

The removal of the state verification requirement, previously included in the Notice of Proposed Rule Making (NPRM), significantly eases the administrative burdens for states. However, it is unclear whether existing state and health plan processes for provider specialty designation meet the self-attestation requirement, or whether states must establish new processes. For example, would states that already collect information on board certification through one of the approved boards be able to use that data to identify eligible PCPs? At a minimum, states should be prepared to document how current processes align with the self-attestation requirements. Some states may need to quickly establish new self-attestation processes via their provider relations team. Further guidance from CMS regarding what the annual review should include would also be helpful. At a minimum, states should assess the extent

to which they will be able to confirm physician self-attestation through either a review of board eligibility or through an analysis of provider claims.

Key questions for states include:

- What methods will the state employ to solicit and accept provider self-attestation? How do current provider specialty designation methods align with the accepted board certifications or claims requirements? Alternatively, can the state easily establish a self-attestation process?
- What rules govern the practice of physician extenders, with respect to physician supervision?
- How did the state reimburse physician extenders in 2009 (e.g., as a percentage of PCP rates)? Has this method changed since then? Can the state easily apply the same method to the 2013 and 2014 Medicare rates?
- What methods will the state use to engage in the annual review of a "statistically valid sample of physicians" as required by these regulations?
- What processes will support applying the increase to out-of-network providers who are eligible PCPs?

## 2. Identifying the Primary Care Services Covered

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The ACA specifies a set of Healthcare Common Procedure Coding System (HCPCS) E&M and vaccination administration codes as eligible for higher reimbursement. These include E&M

### Where the Final Rule Takes a Restrictive Approach

Though the final rule provides flexibility in many areas, including identifying providers eligible for the rate increase, for some issues it takes a more restrictive approach. For example, the final rule makes clear that services provided to youth through a CHIP stand-alone program would not be eligible for 100 percent FFP, while those covered by a CHIP Medicaid expansion program would be eligible for the increased rates. Certain physician specialties that often provide primary care services are not included as eligible providers – OB/GYNs and emergency physicians, for example, as they do not fall under the statutory list of eligible providers/specialists. Physicians delivering services via Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) also do not qualify. Similarly, the final rule indicates that Medicaid PCPs are not eligible for the Medicare Incentive Payments for Primary Care Services authorized by section 5501(a) of the ACA.

codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors. This includes codes established, but not covered by Medicare. Similar to existing rate-setting methods, CMS confirms that it will set these rates for 2013 and 2014 based on the conversion factor and the relative value units (RVUs) assigned to those codes. Specifically, the final rule includes the following E&M codes that are not reimbursed by Medicare, which account for six percent of codes billed by Medicaid PCPs:<sup>16</sup>

- New Patient/Initial Comprehensive Preventive Medicine—codes 99381 through 99387;
- Established Patient/Periodic Comprehensive Preventive Medicine—codes 99391 through 99397;
- Counseling Risk Factor Reduction and Behavior Change Intervention—codes 99401 through 99404, 99408, 99409, 99411, 99412, 99420 and 99429; and
- E&M/Non Face-to-Face Physician

Service—codes 99441 through 99444.

The final rule notes that states are not required to pay for eligible codes if they do not already do so as part of their Medicaid programs. For codes that were not covered by a state in 2009, but have been added since, the rule confirms that the 2009 rate should be considered \$0 and that 100 percent FFP will be available for the entire payment.

As a first step, states should create a crosswalk of the primary care and childhood immunization codes currently used by Medicaid and the Medicare E&M codes eligible for increased reimbursement. States that use primary care codes other than E&M codes must create a crosswalk of those codes to the eligible E&M codes in order to qualify for the enhanced match. This crosswalk can also help states understand which codes, if any, are currently not covered, and determine whether to cover those under the regulation.

Key questions for states include:

### The Role of Physician Extenders

Under the final rule, physician extenders, such as physician assistants (PAs), nurse practitioners (NPs), and nurse midwives can also receive increased payment for designated services, as long as they practice under the personal supervision of a physician with professional responsibility for the services provided. The final rule eliminates the requirement that physician extenders bill under an eligible physician's billing code. Given the increasing importance of physician extenders in primary care, this provision can help attract these providers to serve in the Medicaid provider network. States should inform physician extenders of this opportunity. However, this still presents challenges for states in which extenders deliver care as independent providers, unaffiliated with and unsupervised by a physician. It is also unclear: (1) whether states are expected to verify whether the physician extender is practicing under the supervision of a physician; and (2) if physician extenders must also self-attest.

The final rule specifies that in 2013 and 2014 a state must reimburse for services provided by these extenders in the same manner in which it reimbursed for the services in 2009. For example, if a state paid NPs at a percentage of the physician fee schedule, this methodology must remain in place. Thus, an NP who previously received a percent of physician reimbursement rates is not eligible for the full rate in 2013 and 2014. The state would simply calculate the differential as the difference between the percentage of 2009 rates and the same percentage of 2013 and 2014 rates.

- Does the state use codes other than E&M codes for which the state must develop a crosswalk to eligible E&M codes? If so, how do those codes map to E&M codes?
- What codes, if any, did the state not cover in 2009 that it intends to cover in 2013 and 2014?

### 3. Understanding Baseline Primary Care Rates for Fee-for-Service as of July 1, 2009

Identifying Medicaid primary care rates as of July 1, 2009 is the first step to calculating the differential eligible for federal match. CMS has contracted with a technical assistance provider, Deloitte, to assist states with this work. Deloitte will be developing a state-specific database that identifies Medicaid state plan rates for each E&M code specified in the final rule as of July 1, 2009 as well as 2013 and 2014 Medicare rates for each code. The database will also include information on the payment differential eligible for 100 percent FFP on a per code basis. While this will be helpful, there are caveats that states should note.

*Medicaid Fee Schedule Changes After 2009*  
 The final rule affirms that states that have lowered their primary care rates since July 1, 2009 must also pay at Medicare rates, but are only eligible for the 100 percent match for the difference between the July 1, 2009 Medicaid rates and Medicare 2013 and 2014 rates. The difference between the Medicaid July 1, 2009 and the lower current Medicaid rates will be matched at the existing Federal Medical Assistance Percentages (FMAP) rates, and is not eligible for the 100 percent match. The rule is silent on the implications for states that have raised primary care rates since July 1, 2009. Our interpretation is that those states will be eligible for 100 federal match for the full differential between Medicaid July 1, 2009 rates and Medicare 2013 and 2014 rates. States that have increased their

rates should seek clarification from CMS on this issue.

#### *Supplemental Payments*

The final rule indicates that states must identify any additional supplemental payments (e.g., supplemental payments for physicians affiliated with an academic medical center) in determining the July 1, 2009 Medicaid rate. CMS has clarified that the inclusion of the additional supplemental payment to rates should only apply to providers who were subject to the supplemental payments initially. The final rule also makes clear that pay-for-performance or other incentive programs should not be included in this baseline as these payments are not made as increases in fee schedule amounts.

#### *Vaccine Administration Codes*

For the administration of vaccines under the Vaccines for Children (VFC) program, calculating base rates will require additional work for states, given that the structure of pediatric vaccine codes was changed in 2011. To establish the rates for the vaccine administration billing codes, states must impute the rate for code 90460, the current vaccine administration code, based on the average payment amount for 2009 codes 90465 and 90471 weighted by service volume. States will need to assess the degree to which they can easily access service volume information for the 2009 vaccine administration codes to facilitate this calculation.

States will be required to reimburse VFC providers at the lesser of the 2013 and 2014 Medicare rates or the maximum regional VFC amount in those years (see the final rule for the updated rates by state). The differential between the imputed 2009 rate for code 90460 and the lesser of the 2013 and 2014 Medicare rates or the maximum regional VFC amount in those years is 100 percent funded through an enhanced FFP.

The final rule also notes that in 2009, some states used a single billing code to bill for both the vaccine and the administration fee. According to the final regulations, those states are required to identify the 2009 payment for vaccine administration separate from the vaccine itself so that the differential for the vaccination administration with the 2013 and 2014 Medicare rates can be calculated. This may prove challenging for these states. States in this situation should quickly work to identify the data sources necessary to separate out the administration cost from the vaccine cost, if possible. The final rule notes that CMS intends to provide future assistance to states on ways to modify the immunization administration codes so that they can be used properly but still capture vaccine-specific information. It is not clear, however, whether such a change will be practical for states that have long billed using a single vaccination code.

Key questions for states include:

- What Medicaid fee schedule changes has the state made since 2009? How will these changes impact the state's determination of the 2009 baseline rates?
- What additional supplemental payments did the state make as part of its fee schedule that it will need to take into account when determining the 2009 Medicaid baseline rates for eligible codes?
- If the state previously used a single vaccine billing code to bill for both the vaccine and the administration fee, can the state readily separate the administration cost from the cost of the vaccine itself? What data is available on the vaccine administration cost as of July 1, 2009?

#### 4. Adjusting the Rates for Eligible Primary Care Services

CMS typically publishes the Medicare fee schedule in November prior to the upcoming calendar year. States are given the option to apply the rate increase as an add-on to existing payment methodologies or in lump sum payments, which must be paid on a quarterly basis at minimum. Given that this provision requires states to identify and differentially reimburse a subset of providers, states will need to ensure that their Medicaid Management Information Systems (MMIS) are configured to accommodate the new fee schedules for eligible PCPs. For example, some states may need to develop a new field within their provider database in order to reimburse this subset of PCPs at the Medicare rates. If this approach is administratively burdensome or resource intensive, states may want to consider using lump sum payments to distribute the rate increase.

CMS often makes mid-year updates to the Medicare Physician Fee Schedule (MPFS). With the final rule, states are given flexibility regarding whether they incorporate such adjustments, or not. If the state elects to account for these updates, it must submit a methodology to CMS that specifies the timing.

##### *Site of Service and Geographic Locality Adjustments*

The use of site of service and geographic locality adjustment factors may represent a departure from current fee schedule structures for many states. In an effort to reduce administrative burdens, states have flexibility on whether to not to apply the Medicare site of service and geographic locality adjustments to the fee schedule. While states are free to do so, if a state

#### Excluded – Code 90461 – Additional Vaccine/Toxoid Components

According to the final rule, CMS does not intend to reimburse for code 90461 – the final rule sets the rate for this code at \$0. The final rule explains its logic by noting that code 90461 is for additional vaccine/toxoid components, but that the VFC program does not give CMS authority to make multiple payments for a single vaccine administration. The final rule indicates that it was not the intent of the Affordable Care Act to supersede the VFC program.

decides to not apply site of service adjustments, the rule indicates that all codes should be reimbursed at the Medicare office rate. As an alternative to using Medicare geographic locality adjustments, many of which do not match with Medicaid payment regions, states can develop a single rate based on the mean over all counties for each of the allowed E&M codes.

Given the time sensitivity associated with this final rule, states should quickly identify the processes, time, and resources necessary for creating and uploading the new fee schedules.

Key questions for states include:

- To what extent can MMIS easily identify eligible providers and apply a new fee schedule to those providers? If systems can be easily configured, states may choose to apply the increase incrementally and apply any Medicare mid-year adjustments. If not, lump sum payments may be the easiest option.
- Does the state currently have multiple payment regions? For various policy reasons, a state may wish to retain some variation in regional payment levels and apply the Medicare regions rather than a statewide Medicare average.
- Does the state currently apply a site of service differential similar to Medicare? If so, the state may choose to continue this practice for administrative and policy reasons.
- What is the state's longer term payment strategy? As states move away from FFS toward more value-based payment approaches, the lump sum payment approach could be used to transition PCPs to new payment methodologies.

## 5. Implementing the Rate Increase in Managed Care

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By far the most challenging aspect of this rule is implementation within managed care, where both health plan and PCP payments are less grounded in E&M fee schedules and there is wide variation in PCP payment levels and methodologies. As indicated in the final rule, CMS expects PCPs participating in managed care to receive the payment increase uniformly, at the full Medicare payment rate. However, the final rule does not specify how this requirement be met, noting that managed care contracts between states and managed care organizations (MCOs), prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) vary widely.

### *Approval of Methodologies*

By the end of the first quarter of CY 2013, states are required to submit methodologies for how they will calculate within managed care: (1) the 2009 baseline rate; and (2) the payment differential. In review of state proposed methodologies, CMS has indicated that it will focus on the reasonableness and accuracy of the methods proposed by states, which could provide states the flexibility to develop approaches tailored to their market needs. States must develop a single methodology for estimating the 2009 primary care baseline rate, but this rate does not need to mirror the full set of FFS E&M codes. Rather, states are encouraged to use the best data available, whether that is actual claims data or actuarial assumptions used to build health plan capitation rates.

The rules present one potential methodology for estimating the baseline, which provides guidance for how states can develop their unique methodology. CMS suggests that states develop a 2009 monthly primary care payment rate baseline by:

1. Identifying the proportion of capitation linked to primary care;
2. Identifying the rate incorporated into the actuarial model for primary care services represented by the proportion of payment for primary care services;
3. Determining the annualized cost built into the actuarial model for primary care; and
4. Calculating the monthly payment associate with the annualized cost.

The final regulations provide little guidance about how states can develop a Medicare 2013 and 2014 rate that is comparable to this baseline, but this latitude provides states a wide degree of discretion for how to implement the rate increase in managed care arrangements. States must work closely with their actuaries and health plans to identify the appropriate data sources and unique assumptions that will underlie the methodologies. It is likely that states will need additional guidance on developing these required methodologies. CMS has contracted with a technical assistance provider, Deloitte, to assist states with managed care implementation, including the development of a technical guidance document, which will be a reference tool for states performing FFP differential calculations. This reference tool will include possible methodologies states can use to calculate the differential.

Those states that have shifted Medicaid populations into managed care since July 1, 2009 should be aware that if their managed care fee schedules are higher than FFS rates were on July 1, 2009, then this shift may represent a rate increase over the July 1 baseline, eligible for the 100 percent federal match. States may be eligible for reimbursement by CMS for that differential as well. In order to benefit, states will need to establish a mechanism to identify that population and the associated differential owed to the state.

The final rule indicates that if the methodologies required for implementation of the rate increase in managed care are not approved in time for the enhanced reimbursement by January 1, 2013, states will need to clarify how they plan to implement payment retroactively to the beginning of the year. The rule notes that states and contracting MCOs have the option of issuing payment for primary care services in accordance with existing contracts for CY 2012 or under contracts executed under standard contracting schedules for CY 2013 that do not account for the increased payments. Once CMS approves the methodology and contract amendments, states will have the flexibility to re-adjudicate eligible claims paid in CY 2013 to account for the enhanced rates. Presumably states can also retrospectively apply lump sum payments to health plan capitation rates, using the approved methodology, as well. As mentioned above, states can alternatively pay providers prospectively, and retrospectively reconcile with documented expenditures. Regardless of which method a state chooses, the MCOs will be required to direct the full amount of the enhanced payment to the eligible provider, without any effort on behalf of the provider.

#### *Updating Contracts*

As a condition of the final rule, MCOs are required to ensure that eligible PCPs receive the Medicare level of payment for eligible services rendered, regardless of whether a provider is paid via capitation or some other non-volume-based payment methodology. Additionally, CMS has indicated that the increase must be paid through MCOs in managed care environments – the increase cannot be paid by the state directly to providers who contract with the MCOs. As such, states will need to update all managed care contracts to ensure this and other conditions. Specifically, the final regulations require that all managed care

contract amendments must include provisions which:

1. Provide for payment at the minimum Medicare levels;
2. Require that eligible PCPs receive direct benefit of the increase for each of the primary care services specified in the rule;
3. Require that all information needed to adequately document expenditures eligible for 100 percent FFP is reported by MCOs to the states which, in turn, will report these data to CMS; and
4. Specify that state must receive data on primary care services which qualify for payment under this rule.

CMS has indicated that it intends to develop and provide states with standardized contracting language that states can use. However, CMS has indicated that this language will not be available before January 2013.

States are provided discretion to determine the documentation that they will need from health plans to substantiate that the Medicare rates are provided to eligible PCPs. While CMS anticipates in the final rule that encounter data should be sufficient for the states to undertake verification activities, this may not be viable in states with extensive subcapitation arrangements or incomplete encounter data. States must work with health plans to determine what additional documentation might be readily available which can be used for these purposes, without being administratively burdensome. Given the time and resources that states must devote to reviewing and revising all Medicaid managed care contracts, it is incumbent upon states to initiate these activities as soon as possible.

One outstanding question is whether the health plan payment documentation will

## FFP in Payments for Individuals Eligible for Medicare and Medicaid

### Current Situation

For services provided to an individual eligible for Medicare and Medicaid, Medicare reimburses physicians 80 percent of its fee schedule. Currently, states have three options for such payments consistent with section 1902(n) of the Social Security Act:

- A state may pay the provider the full amount necessary to result in aggregate payment to the provider equal to the Medicare rate.
- Only the amount (if any) to result in aggregate payment equal to the state's Medicaid rate.
- A separately CMS-approved methodology.

### PCP Rate Increase

The final rule for Section 1202 notes that, since Medicaid rates are to be equal to Medicare rates for 2013 and 2014 for eligible codes, physicians should receive up to the full Medicare rate for primary care services. As with all eligible codes for this provision, 100 percent FFP will be available for the full amount of the Medicare cost sharing difference that exceeds the amount that would have been payable under the state plan in effect on July 1, 2009.

As with other managed care plans, states in which Duals Special Needs Plans (DSNPs) operate will need to work with these plans to ensure that providers directly receive the increased rates for which they are eligible. Though the final rule does not require states to amend contracts with DSNPs, states may want to consider doing so as a means to codify the rate increase pass-through to eligible providers. As with other managed care plans, states will also be required to develop a methodology for identifying the difference in capitation rates and to claim enhanced FFP for the difference. This may be more complicated for DSNPs as not all states have enrollment and adjudication processes that mirror Medicare's processes for handling crossover claims in place.

be used not only to verify that plans are paying PCPs the Medicare rates, but also to verify that the differential capitation adjustments have been paid fully to PCPs. Using this data for the latter purpose would be problematic since: (1) encounter data is often incomplete, and (2) the primary care portion of a Medicaid health plan capitation payment may not precisely equal what health plans currently expend for primary care.

Key questions for states include:

- How do actuaries incorporate primary care expenditures into MCO rates? What key assumptions, such as payments to FQHCs and the utilization trend rate, underlie that process?
- Do the actuarial models take into account Medicare payment localities, facility setting and physician specialty type for primary care payments?
- Do primary care rates vary by MCO? If so, the state will need to ensure that the rate increase that gets passed on to providers is the same regardless of rate variations between MCOs.
- What specific data elements must be collected to document payments were made to eligible providers?
  - How complete is the managed care encounter data?
  - What data or documentation would be available for salaried PCPs or those under sub-capitation arrangements?
- What resources will be necessary to update contracts with health plans? Who will need to be involved in the deliberations with the health plans to update contracts?

## **6. Developing a SPA to Reflect the Fee Schedule Increase for Eligible Providers**

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The final rule requires states to file a SPA for this rate enhancement and will have until March 31, 2013 to do so. To assist with this effort, CMS is providing states

with a SPA template. In addition to documenting the new fee schedule, states must identify:

1. Whether they will make site of service adjustments or use the Medicare rates applicable for the office setting and if so, what the methodology will be;
2. Whether the state will use Medicare geographic adjustments or develop a statewide rate per code that reflects the mean value over all counties of the Medicare rate and if so, what the methodology will be;
3. The manner in which the state intends to make the higher payment (that is, as an increase to the fee schedule or as an aggregate quarterly supplemental payment);
4. A crosswalk of primary care codes to eligible E&M codes, if state does not use E&M codes; and
5. Those codes which the state will pay at higher rates and the codes that have been added to the fee schedule since 2009.

States must notify providers of changes in their fee schedule. States alert physicians of rate changes through various methods – some publish rates in their state register while other engage in outreach to providers via Medicaid newsletters, formal letters or direct emails to providers. States should also consider holding informational webinars or conference calls to update providers on the fee schedule changes, as well as on other aspects of the rate increase. States can also consider informing providers of changes in the fee schedule through third-party organizations; for example, states can partner with state medical societies or large integrated provider groups to engage a large number of providers. States should determine the methods which work best for them while adhering to federal regulations regarding changes to Medicaid fee schedules.

Key questions for states include:

- How much time and what resources will be necessary for the state to develop the required SPA?
- What method will the state use to notify eligible PCPs of rate changes?

## **7. Claiming and Reporting FFP**

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With the final rule, CMS confirmed that states can claim the 100 percent FFP available through the rate increase based on the approved rate differential methodology they are required to develop. The rule indicates that depending on the best data available, this may result in an imputed payment differential that is based on actual claims or actuarial assumptions. Reporting instructions for both fee-for-service and managed care will be provided to states before the end of the first quarter of CY 2013.

Key question for states includes:

- Given your state's current FFP reporting methodology, will the state need to impute the payment differential based on actual claims or actuarial assumptions?

## **8. Measuring and Enhancing the Payment Increase's Impact on Access to Care**

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As the proposed rule for the rate increase indicated, a primary aim of this provision is to "promote access to primary care services in the Medicaid program before and during the expansion of coverage that begins in 2014."<sup>17</sup> In light of historically low Medicaid reimbursement for primary care services,<sup>18</sup> the rate increase provides states with an opportunity to encourage providers to increase the panel size of their Medicaid populations or begin to serve Medicaid patients, if they do not already do so. To understand the impact of the rate increase, the final rule requires that states collect and report to CMS data

on the extent to which the higher rates increase physician participation. This data will assist Congress in determining whether or not to continue the higher rates beyond 2014. The rule notes that the form and timeframe for the data submission has yet to be determined by CMS. A brief by CHCS specifically focuses on measuring the impact of the rate increase.<sup>19</sup> States can review this document to consider metrics that the state may have at hand which can inform the impact of the rate increase on physician participation and access to care.

To facilitate greater physician participation in Medicaid, and to achieve better access to care for Medicaid beneficiaries, states should consider the following steps:

1. Engage PCPs around the rate increase by identifying and convening key stakeholders and by developing an effective outreach strategy and work plan;
2. Target regions of opportunity, where the increase in rates may be greatest, where Medicaid participation is low, and where access to care is low;
3. Address PCP reluctance to participate in Medicaid due to non-reimbursement related factors, such as payment delays and administrative barriers and complexity; and
4. Assess the impact of the rate increase by measuring changes in provider willingness to see Medicaid beneficiaries and changes in health care utilization resulting from greater primary care access.

An earlier CHCS brief details these and other steps that states can take to achieve greater physician participation and greater access to care for existing and potential Medicaid beneficiaries.<sup>20</sup>

Key questions for states include:

- What metrics does the state have through its MMIS system that can be

used to assess the state of access and to track changes in access overtime? What other metrics are available that can be used for this purpose?

- What stakeholders would the state want to participate in a provider outreach strategy workgroup?
- What is the state of Medicaid's current relationship with specialty societies? Has Medicaid previously worked with the societies in outreach efforts to providers?
- How can your state leverage its MCO contracts to improve access?
- What communication and dissemination routes would work best for engaging the provider community around this issue?

## Conclusion

With the significant expansion of health care coverage beginning in 2014 through ACA implementation, it is imperative that the United States' primary care infrastructure is strengthened. Medicaid, in particular, expects to see a majority of the expansion in terms of newly eligible beneficiaries. Yet, access to care has been,

and will likely continue to be a challenge for state Medicaid programs. The increase in reimbursement for eligible primary care services to Medicare rates in 2013 and 2014, is one attempt to help mitigate the access problems that states face.

With the release of the final rule associated with this reimbursement increase, states can now begin to take the necessary steps to implement the provision. Given the very brief period between the release of this final rule and implementation in 2013, states should immediately review the final rule and initiate implementation planning. Once implemented, the reimbursement increase will help ensure that Medicaid beneficiaries have access to high quality primary care.

### ***Leveraging the Medicaid Primary Care Rate Increase***

This brief is a product of *Leveraging the Medicaid Primary Care Rate Increase*, a Center for Health Care Strategies (CHCS) initiative made possible by The Commonwealth Fund. Through this initiative, CHCS is working with state Medicaid agencies and health plans in seven states, as well as with the Centers for Medicare & Medicaid Services, on the implementation of the Medicaid primary care rate increase mandated under health care reform.

### **About the Center for Health Care Strategies**

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. Visit [www.chcs.org](http://www.chcs.org) for more information.

## Endnotes

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