CHCS Center for Health Care Strategies, Inc.

FACT SHEET

Overview: Proposed Federal Rules for Increased Medicaid Payment for Primary Care Providers

MAY 2012

On May 9, 2012, the Department of Health and Human Services (HHS) released proposed regulatory language for implementing the Medicaid primary care rate increase under Section 1902(a)(13) of the Affordable Care Act (ACA). The purpose of the provision is to encourage more physicians to participate in Medicaid, and thereby promote access to primary care services for current and new Medicaid beneficiaries to be served via coverage expansion in 2014. The proposed rule is intended to provide states with appropriate direction for implementing this provision within both managed care and fee-for-service delivery systems. This summary provides an initial overview of HHS' planned regulatory approach and briefly outlines next steps for states.

IN BRIEF

In 2013 and 2014, under the Affordable Care Act, Medicaid is required to reimburse primary care providers at parity with Medicare rates—a "bump" that is funded 100 percent by the federal government. This fact sheet summarizes the proposed federal regulations released on May 9, 2012. It was prepared by the Center for Health Care Strategies as part of the *Leveraging the Medicaid Primary Care Rate Increase*, a national initiative made possible by The Commonwealth Fund, with additional support from the New York State Health Foundation.

To review the proposed rule, "Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program," visit: https://federalregister.gov/a/2012-11421.

What this Proposed Rule Covers

The proposed rule outlines new requirements for state Medicaid agencies to reimburse certain physicians with at least Medicare rates for primary care services furnished in 2013 and 2014. It defines eligible physicians, identifies eligible primary care services, and addresses how states should calculate the increased payment for federal matching purposes, which will be reimbursed at a federal match rate of 100 percent. The proposed rule also provides guidance for states to implement the provision within managed care.

Proposed Regulations Governing the Medicaid Primary Care Rate Increase

Eligible Providers: The proposed regulation takes a broad approach to provider eligibility. All specialists and subspecialists recognized by the American Board of Medical Specialties within the three specialty designations – family medicine, general internal medicine, and pediatric medicine – would be eligible for increased payment for primary care services. The proposed rule specifies that states must establish a process through which physicians must declare – and states then verify – that they are in fact eligible practitioners in that specialty or subspecialty. For physicians who are not certified by the American Board of Medical Specialties, the proposed rule defines a method for determining eligibility, which aligns with the methods used for the Medicare Incentive Payments for Primary Care.[1] Certain physicians groups outside of these specialty designations who perform primary care services, such as OB/GYNs, are not included as eligible for increased payment. Federally qualified health centers and rural health centers are excluded as well because they are reimbursed at cost under the Medicaid prospective payment system.

[1] *Primary Care Incentive Payment Program (PCIP) Eligibility for New Providers Enrolled in Medicare*, CMS Manual System, Pub 100-04 Medicare Claims Processing, Department of Health and Human Services, February 11, 2011. Available at http://www.cms.gov/Transmittals/downloads/R2152CP.pdf.

Physician Extenders: Primary care services would be reimbursed at the Medicare rate if those services were properly billed under the provider number of an eligible physician, regardless of whether the services were delivered by the physician or by physician assistants or advance practice nurses, for example, under the physician's personal supervision.

Covered Services: The proposed regulations endeavor to include all primary care services enumerated in the statute, including those not covered by Medicare. Healthcare Common Procedure Coding System (HCPCS) E&M codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474 or their successors would be eligible for higher payment. This includes primary care codes that Medicare does not currently cover but for which it publishes and sets relative value units (RVUs). In the proposed regulations CMS, solicits comments regarding the most appropriate way to price services not covered by Medicare.

Applicable Medicare Payment Fee Schedule: The proposed rule would require states to use the Medicare rate applicable to the site of service and geographic location of the provider, which varies under Medicare fee schedules. States would have discretion over whether to set a fixed annual fee schedule based on rates Medicare establishes at the beginning of 2013 and 2014 or to make adjustments reflecting Medicare changes made during the year. The applicable Medicare rate would be whichever is greater, either rates in 2013, 2014 or Medicare 2009 rates.

Implementation within Managed Care Organizations: The proposed rule strives to ensure that managed care organizations (MCO) implement the increase uniformly and that the contracted primary care network receives the full Medicare rate, just as they would under fee for service. All MCO contracts would be revised to provide for payment at the minimum Medicare primary care payment levels for all eligible providers and must stipulate that eligible physicians receive the full and direct benefit of the increase. MCOs (including Pre-paid Inpatient Health Plans and Pre-paid Ambulatory Health Plans) must report all information needed to adequately document expenditures eligible for 100 percent federal match to the states which, in turn, will report these data to the Centers for Medicare & Medicaid Services (CMS). The proposed rule suggests an approach that states may take to align managed care capitation rates with the rate increase, but also provides flexibility for states to define their own capitation rate adjustment methodology and submit it to CMS for approval.

Provisions for Vaccinations: To address the 2011 change to the pediatric immunization coding structure (i.e., two codes replaced four prior codes), CMS proposes that states impute the 2009 rate for code 90460 based on the average payment amount for the deleted codes weighted by service volume. Additionally, CMS proposes that the rate for code 90461 should be $0.

Additional state considerations outlined in the proposed rule include:

- States must develop a method to identify the rate differential and document the difference between the July 1, 2009 Medicaid rate and the applicable Medicare rate for specified providers that is claimable at the 100 percent federal matching rate.
- The proposed rule does not explicitly address how states using advanced payment methodologies (e.g., pay-for-performance, bundled payments) would incorporate the rate increase into those methods. Further clarification from CMS would be helpful.
- States must file a State Plan Amendment to reflect the fee schedule rate increases. The purpose of this proposed requirement is to assure that when states increase reimbursement to providers, they have State Plan authority to do so and they have notified providers of the change in reimbursement as required by Federal regulations.
- States with rates that are currently higher than rates as of July 1, 2009 are eligible for federal reimbursement of the full difference between Medicare 2013 and 2014 rates and the Medicaid July 1, 2009 rates at the 100 percent federal matching rate.
- The proposed rule updates the interim regional maximum fees that providers can charge for the administration of pediatric vaccines under the Vaccines for Children (VFC) program, with the difference funded at 100 percent federal match. CMS proposes to utilize the Medicare Economic Index, used to update Medicare physician payments, to adjust the national average administration charge from 1994, the last time the interim regional maximum administration fee was updated.

Next Steps for States – What They Can Do Now

Though the HHS proposed rule is not final, there are steps that states can take immediately to evaluate implications of the proposed primary care rate increase for their Medicaid provider networks:

- **Provide input to HHS on the proposed rule**. Send comments by June 11, 2012 to: http://www.regulations.gov.
- **Evaluate the fee schedule.** Review fees as of July 1, 2009 for alignment with Medicare site of service and Medicare payment regions.
- **Identify strategies to document the rate differential**. Begin by evaluating methods to identify rates that have increased since July 1, 2009 and methods for documenting the qualified rate differential.
- **Identify how primary care rates are built into MCO capitation rates**. Gather information to identify potential methodologies for revising MCO capitation rates to reflect the rate increase. Seek input from MCO stakeholders.
- **Determine MCO reporting options.** Explore how to facilitate MCO reporting of eligible expenditures.
- **Explore strategies for provider identification**. Identify processes for providers to confirm their specialties and for states to verify provider specialties and update provider information systems. Assess MMIS capacity to adjudicate claims based on physician specialty. Engage relevant stakeholders in determining appropriate processes, including state and local medical societies.
- **Identify physician outreach strategies.** Determine approaches to reach those who may be eligible, including physician extenders, and those not currently serving Medicaid patients. Begin to develop key messages and essential communications materials.

Conclusion

This summary provides a brief snapshot of key requirements contained in the proposed rule governing the Medicaid 2013-2014 primary care rate increase. The primary care rate increase gives states an opportunity to sustain and potentially increase Medicaid beneficiaries' access to critical primary care services. When aligned with other efforts to strengthen primary care, such as health homes, patient-centered medical homes, and accountable care organizations, and with other Medicaid payment reform efforts, this rate increase can be a powerful tool for states. However, challenges remain for states to implement the increase in a manner that both maximizes the benefits for primary care providers and their patients, while making the most efficient use of scarce state resources. With funding provided by The Commonwealth Fund, and additional support from the New York State Health Foundation, the Center for Health Care Strategies (CHCS) is working with six leading-edge states to implement the increase efficiently and leverage the increase for achieving broader delivery system improvement. Through that effort, CHCS will share additional analyses and tools with states, health plans, and other interested stakeholders.

Leveraging the Medicaid Primary Care Rate Increase

This overview 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, with additional support from the New York State Health Foundation. Through this initiative, CHCS is working with Medicaid stakeholders in six states, as well as with the Centers for Medicare & Medicaid Services, to implement the Medicaid primary care rate increase mandated under health care reform. Further analyses will provide more information regarding the proposed rule.

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 Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. Its core priorities are: enhancing access to coverage and services; improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity. Visit www.chcs.org.