Medicaid Primary Care Rate Increase Final Rule: Fast Facts

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) released the final regulations governing the implementation of the Medicaid primary care rate increase to Medicare levels for 2013 and 2014. As the convener of a multi-state collaborative on the rate increase, the Center for Health Care Strategies (CHCS) prepared this summary, highlighting select provisions for states to consider when planning implementation.

IN BRIEF

This resource 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 and the Massachusetts Medicaid Policy Institute. Through this initiative, CHCS is working with Medicaid stakeholders in seven states, as well as with the Centers for Medicare & Medicaid Services, to help translate CMS guidance and implement the Medicaid primary care rate increase mandated under health care reform. CHCS will provide a more in-depth and comprehensive analysis in the near future.

Eligible Providers

- Higher payment is limited to the qualified physicians and advanced practice professionals practicing under their personal supervision, but services no longer need to be billed under the physician's billing number, as long as the physician has professional responsibility for the services provided. However, state payment rules regarding advanced practice professional rates, relative to physicians, must remain in place. For example, if a states' fee schedule reimburses nurse practitioners at 80 percent of rates received by physicians, this relationship must remain in place.
- Physicians must self-attest that they are appropriately Board certified or that 60 percent of their Medicaid claims are for eligible evaluation and management (E&M) codes. States are not required to validate this attestation, but must review a statistically valid sample to verify that the PCPs met the requirements.
- The rule permits recognition of physician specialties and subspecialties by the American Board of Physician Specialties and the American Osteopathic Association as well as the American Board of Medical Specialties.

Eligible E&M Services

- States are not required to pay for codes that are not reimbursable under their Medicaid program. In a State Plan Amendment (SPA), Medicaid agencies must identify the eligible codes that will be paid at the Medicare rate in CYs 2013 and 2014 that were not paid as of July 1, 2009 (see below for more on SPA requirements).
- CMS will develop rates for E&M codes which Medicare does reimburse, based upon the Medicare Conversion Factor and Relative Value Units assigned to those codes.

Medicare Fee Schedule

- States are not required to use Medicare site of service adjustments, nor Medicare payment regions. Rather, states may use the Medicare office rate and may either use all Medicare geographic adjustments, or develop a single rate based on the mean for over all counties for each of the E&M codes specified in this rule.

- The rate increase may be made as either add-ons to existing rates or as lump sum payments, on at least a quarterly basis.
- States have flexibility in determining whether to, and how often to, update rates to conform to changes in the Medicare rates.
- The 2009 Medicaid base payment calculations exclude incentive, bonus, and performance-based supplemental payments. Other volume-based payments, particularly those associated with academic medical centers, must be included.

Managed Care

- CMS does not specify the methodology a state must use to meet the statutory requirements under managed care. No later than the end of the first quarter of CY 2013, states must submit two methodologies that calculate:
  1. The 2009 baseline rate
  2. The payment differential
- CMS will focus on the reasonableness and accuracy of the methods proposed by the state. States may use various sources of data to establish base costs and utilization trends including FFS data, Managed Care Organization (MCO) financial data, or a combination of both.
- MCOs are required by regulation and contract to ensure that eligible PCPs receive the appropriate rate increase for primary care services rendered. To obtain CMS regional office approval of their managed care contracts, states must demonstrate that the higher payment will be passed on for services furnished by the PCPs designated in statute. CMS anticipates that encounter data will be sufficient for the states to undertake verification activities.
- States must specify the documentation needed from health plans to substantiate that the enhanced rate was delivered to eligible PCPs. Documentation must be made available to the state and CMS for verification and for audit or reconciliation processes.
- CMS will review managed care contracts to ensure that they:
  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 federal financial participation (FFP) is reported by MCOs to the states which, in turn, will report these data to CMS; and
  4. Specify that states must receive data on primary care services that qualify for payment under this rule.
- If the methodology is not approved in time for enhanced reimbursement on January 1, 2013, the state will need to clarify to CMS how it will implement payment retroactively to the beginning of the year.
  1. The state 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.
  2. Once the state receives CMS approval, the state will adjust its rates previously paid to the MCOs to reflect the enhanced payment.
  3. All eligible claims paid in CY 2013 prior to CMS approval will be re-adjudicated and the MCO will direct the full amount of the enhanced payment to the eligible provider, without any effort from the provider. CMS will review managed care contracts for this assurance.

State Plan Amendment

- States have until March 31, 2013 to submit a SPA for the rate increase that is effective on January 1, 2013.
- States can either make higher payments to physicians and wait until the SPA is approved to submit claims for FFP, or can pay physicians at the 2012 Medicaid state plan rates and make supplemental payments once the SPA is approved.
- CMS will provide states with a SPA template. The template will require that states indicate:
    1. Whether they will make site of service adjustments or reimburse all codes at the Medicare rate applicable to the office setting;
    2. Whether they will make all Medicare locality adjustments or develop a statewide rate per code that reflects the mean value over all counties of the Medicare rate;
    3. Identify the manner in which the state will make higher payment (that is, as a fee schedule or aggregate supplemental payment; and
    4. Describe the codes which will be paid by the state at the higher rates and the codes that have been added to the fee schedule since 2009.

Claiming Federal Financial Participation (FFP)

- States can claim 100 percent FFP based on the CMS-approved methodology for identifying the rate differential. Depending on the best data available, this may result in an imputed payment differential that is based on actual claims or actuarial assumptions.
- CMS will provide states with reporting instructions before the end of the first calendar quarter of 2013. This guidance will be provided for both FFS and managed care delivery systems.

Data Collection and Reporting

- States are required to collect and report to CMS data on the impact of the higher rates on physician participation. Those data will assist Congress in determining whether or not to extend the provisions of this rule beyond the end of CY 2014.

These CMS regulations will certainly help states implement this important provision of the Affordable Care Act (ACA). Additional questions are likely to arise and CHCS looks forward to helping Medicaid's federal and state partners achieve the ACA's goals for increasing beneficiary access to primary care across the country.

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy resource center dedicated to improving health care 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. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.