CHCS Center for Health Care Strategies, Inc.

Technical Assistance Tool

Implementing the Medicaid Primary Care Rate Increase: A Roadmap for States

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The Affordable Care Act's (ACA) expansion of Medicaid eligibility to 16-20 million new beneficiaries beginning in 2014 could generate unsustainable pressure on Medicaid's already taxed network of primary care providers. To encourage broader primary care provider (PCP) participation in Medicaid and ensure patient access to primary care, the legislation requires Medicaid agencies to increase PCP reimbursement to reach parity with Medicare rates in 2013 and 2014. States will receive up to $8.3 billion in federal funding with the incremental funding financed at 100% by the federal government.[1]

The increased reimbursement could be a powerful tool for bolstering the delivery system, enhancing access, and improving the quality of primary care for current and new beneficiaries. Medicaid must move swiftly to address numerous policy and technical issues underlying successful implementation of the reimbursement increase by 2013, such as: 1) expanding the number of PCPs in the Medicaid network; 2) increasing access and quality measurement efforts; and 3) implementing changes to the provider fee schedule, contracts, and FMAP reporting processes.

Implementing the Medicaid Primary Care Rate Increase: A Roadmap for States is designed to guide states through the planning and implementation process. The roadmap presented below will help states: 1) understand critical parameters of the increase; 2) identify the operational steps and key questions to prepare for and implement the increase and apply for the federal match; and 3) identify potential levers to enhance primary care access and quality. The roadmap will be updated upon release of the Notice of Proposed Rule Making from the Centers for Medicare & Medicaid Services (CMS), providing states with regulatory guidance.

Background

This roadmap is a product of *Leveraging the Medicaid Primary Care Rate Increase*, a Center for Health Care Strategies (CHCS) initiative made possible through support from The Commonwealth Fund. CHCS is working with Medicaid stakeholders, including CMS, state Medicaid agencies, health plans, physician organizations, and health policy experts, to maximize the long-term impact of the primary care rate increase on health care quality and access.

For more information, including a recent policy brief highlighting the critical issues related to primary care payment policy, visit www.chcs.org.

[1] Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Nancy Pelosi providing an analysis of the amended reconciliation proposal, March 20, 2010. Available at: http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

Made possible through support from The Commonwealth Fund.

IMPLEMENTING THE MEDICAID PRIMARY CARE RATE INCREASE: A ROADMAP FOR STATES		
Key Implementation Steps	***Tasks to Complete***	***Key Questions***
1) Identify the primary care services covered in the Section 1202 rate increase. Section 1202 includes E&M codes 99201-99499. However, CPT codes 99241-99255, 99381-99401, and 99408-99450 are not covered by Medicare.	✓ Create a crosswalk of the primary care E&M codes and childhood immunizations currently used by Medicaid and the Medicare E&M codes (99201 – 99499) eligible for increased reimbursement, as specified in Section 1202. Assess and address gaps. ✓ CMS regulations will specify whether states must use Medicare regional rates. To prepare, identify the Medicare regions within your state and the applicable zip codes, if your state does not currently adjust payments by Medicare-defined regions. Create a crosswalk of Medicaid regions and the Medicare regions in your state.	• Do PCPs use codes to bill for primary care services or immunizations, other than those that are eligible for increased rates? • How will CMS require states to handle CPT codes 99445 and 99456, which are covered by Medicare, but paid at $0.00? • Does your fee schedule vary by region? Do the Medicaid payment regions in your state align with the Medicare payment regions? • If your Medicaid payments do not vary regionally, is there more than one Medicare region in your state? If so, can your MMIS vary payments by region of service?

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2) Identify the eligible provider types and places of service.	✓ Evaluate the level of completeness of provider specialty designations within your provider data files. ✓ Map the appropriate MMIS provider type codes to the eligible Medicare provider types. ✓ States with incomplete provider specialty designations will need to identify alternative methods for determining eligibility. ✓ CMS regulations will specify whether states will need to vary rates by place of service. To prepare, assess the data completeness of place of service designation in MMIS. Map the MMIS place of service codes to the appropriate Medicare place of service categories.	• How do you currently collect physician specialty types? Is this info complete and accurate? Do you rely on both primary and secondary specialties to determine eligibility? • Are specialty designations different in FFS and managed care? • Do your physician specialty types map cleanly to the three eligible provider specialties? • Does your state need to develop alternative mechanisms for specialty assignment? If so, what options are currently available? • What is the volume of PCPs you expect will be impacted by the increase? • Physician Assistants' and Nurse Practitioners' reimbursement is often set as a percentage of PCP rates. Will their reimbursement be adjusted with the increase? This will not be covered by the 100% federal match. • Will the bump be tied to billing or servicing provider? • Does your MMIS currently apply different fee schedules by place of service? Does your MMIS have the capability to adjudicate claims payment on the basis of place of service?

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3) Understand the baseline primary care rates for fee-for-service (FFS) and managed care as of July 1, 2009.	✓ Obtain the Medicaid FFS primary care rates in place as of July 1, 2009, for eligible E&M codes. ✓ For Medicaid managed care contracts, evaluate the encounter data for completeness: – If encounter data is accurate and contains claims-level payment information, use the data containing rates in place as of July 1, 2009, to construct a baseline fee schedule for eligible E&M codes. – If encounter data is incomplete, review the actuarial models used for managed care capitated payments on July 1, 2009. Obtain data on the primary care rates used within these models or develop estimates based on these models.	• Can the FFS rates for July 1, 2009 be easily obtained from MMIS? • How complete is the MCO encounter data? Does it include rate data by CPT code? • How do actuaries incorporate primary care service expenditures into MCO rates? • How do primary care rates vary by MCO? Do the actuarial models take into account regional differences and physician specialty type for primary care payments? • What bundled payments for PCPs include primary care services that would otherwise be eligible? Do these bundled services consist of a high percentage of primary care?

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4) Adjust the rates for eligible primary care services: – FFS fee schedule – Managed care capitated payments	✓ Evaluate whether MMIS payment logic can accommodate fee schedules that vary by provider type. If not, configure MMIS payment logic to evaluate or "look up" the provider type on each claim and apply a different fee schedule. Similar modifications by place of service and region may be necessary. ✓ Within FFS, prepare for the 2013 fee schedule by creating a new fee schedule template for eligible specialty types, for eligible E&M codes, and by place of service and region if necessary. Prepare MMIS to upload the new fee schedule. ✓ Evaluate existing actuarial models to determine how new rates can be incorporated. Evaluate whether adjustments should be made regionally for each health plan. Also consider the degree to which the health plan includes Federally Qualified Health Centers in their network, which are not eligible for the rate increase.	• Does your MMIS currently apply different fee schedules by specialty type? • Does your MMIS have the capability to adjudicate claims payment on the basis of specialty? If not, what work-around solutions can be developed? • Does CMS require states to include the 10% Medicare PCP incentive payment as part of the Medicare rates? • What processes need to be in place to create and upload the new FFS fee schedules? How long will this process take and what are the estimated resources needed? • How do actuarial models currently adjust capitation payments on the basis of changes in provider payments? Can the state use these processes to update the capitation payments with the new PCP rates? • Within managed care, what actuarial assumptions are made about primary care delivered through FQHCs, which are not eligible for the increase? • What processes do MCOs need to put in place to update their primary care fee schedules? • What contract changes need to be made to ensure MCOs pay at 100% of Medicare? • What processes need to be in place to manage provider complaints, specific to the rate increase?

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5) Modify FMAP calculation and reporting.	✓ Create a template to crosswalk the baseline rates for eligible FFS codes with the Medicare fee schedule by provider type, place of service, and region. ✓ Develop reports to calculate the rate differential by E&M code, which will form the basis of the FFS federal match. ✓ Develop reports to calculate the expenditures eligible for the enhanced federal match. The reports will need to calculate claims volume by eligible E&M code and, using the old and new fee schedule, apply the appropriate rate differentials to the claims volumes to derive the expenditures eligible for the enhanced match. ✓ Configure reporting systems to calculate, in aggregate, PCP increase differential for eligible services, quarterly. ✓ CMS will provide guidance to states regarding FMAP submission for capitated payments. ✓ Begin discussions with Medicaid managed care organizations (MCOs) about processes to verify that increased rates have been appropriately applied to PCPs contracting with MCOs.	• How will systems need to be adjusted to track the payment differential associated with each FFS claim? • What programming adjustments need to be made to track the differential applied to capitation payments? • What processes need to be in place to generate new FMAP reports? Will reporting processes be different for FFS and managed care? How long will this programming take and what are the estimated resources needed? • Can encounter data be used to verify the rate increases applied by MCOs?

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6) Recruit new providers and maintain the primary care network.	✓ Identify areas within the state where access issues may arise and/or where there is capacity for expanding the provider network. ✓ Develop partnerships with state and local medical societies to conduct physician outreach and recruitment efforts. ✓ Develop communications materials that explain the increase and the positive impact on physician revenue. ✓ Begin to assess areas such as claims documentation requirements and patient verification processes and identify opportunities to streamline those processes for physicians.	• What is the volume of PCPs you expect will be impacted by the increase? • How will the patient-to-PCP ratio change with the expansion of Medicaid? • What is the estimated average revenue impact for PCPs? • Where are regions with a shortage of Medicaid PCPs? • In what regions is there the capacity to recruit new PCPs to accept Medicaid? • What local medical societies could assist with recruitment efforts? • What are effective vehicles for communications with PCPs?
7) Expand quality and access measurement.	✓ Identify quality and access measures that Medicaid health plans and private payers currently collect for physicians or physician groups in your state. ✓ Identify measures that are important for Medicaid populations and feasible to collect using available data: – ARRA/HITECH meaningful use measures – CHIPRA core measures for children – New AHRQ adult Medicaid measures – Measures utilized by Medicaid MCOs to assess care (HEDIS, CAHPS) ✓ Identify national reporting programs that will have measurement reporting requirements in the future. Consider how to leverage the ongoing implementation of these programs to further performance measurement in Medicaid. ✓ Identify key utilization measures that may be impacted by the rate increase.	• Are there existing multi-payer initiatives that Medicaid could participate in and contribute data to? • What access measures does your state seek to impact through the PCP rate increase? • Are Physician Workforce surveys conducted in your state, which you could leverage to measure access? • How can your state leverage its MCO contracts for performance measurement?

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8) Implement advanced primary care payment methodologies.	✓ Assess your state's predominant payment models and readiness for or interest in implementing advanced payment methods such as capitated payments for medical home services, bundled payments, and global payments. ✓ Estimate the anticipated amount of increased primary care expenditures your state is interested in distributing via advanced payment methodologies.	• Which advanced payment method is your state most interested in pursuing? • Are there existing programs to support advanced primary care that the state can strengthen with enhanced revenue? • How much additional revenue is required to fund these reforms? Is this amount less than the additional revenue your state expects as a result of the payment increase to PCPs?
9) Measure the impact of the increase.	✓ Identify key measures that you anticipate will be impacted, such as: o Number of patients per PCP o Number of PCPs accepting new Medicaid patients o Patient Satisfaction measures on timeliness of primary care o ED utilization ✓ Calculate 2012 Medicaid baseline rates for the core measure set. ✓ Develop a program evaluation plan to measure the impact of the increase on patient access to primary care and utilization of unnecessary services.	• What measures does your state seek to impact via the PCP rate increase? • Which measures do you currently collect? Would adjustments be necessary to establish a robust dataset? • Which measures would require new measurement efforts? Can existing data sources support these measures? • Are Physician Workforce surveys conducted in your state, which you could leverage to help evaluate the impact of the increase?

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. In collaboration with state and federal agencies, health plans, providers, and consumer groups, CHCS pursues innovative and cost-effective strategies to better serve Medicaid beneficiaries. Its program 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. For more information, visit www.chcs.org.