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CMCS Informational Bulletin

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SUBJECT: **Increased Medicaid Payment for Primary Care Questions and Answers**

Today CMS is pleased to announce the release of important information for states on the implementation of the Affordable Care Act's provisions to raise payments for services furnished by certain primary care physicians in calendar years 2013 and 2014.

Since the publication of the final rule on November 6, 2012, CMS has received questions from states and other stakeholders about this provision. CMS has developed two Question and Answer documents to address many of the questions we have received to date, one document related to fee-for-service implementation issues and a second on managed care delivery system implementation issues. We hope this information will be helpful.

The Questions and Answers may be accessed at: <http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/CMCS-Ask-Questions.html>

Under the provisions of the regulation, states are required to amend their Medicaid state plans to increase payment rates; therefore, CMS has issued a state plan preprint for this purpose. The preprint "Reimbursement Template -Physician Services, Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415," may be accessed at: <http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html>

**Qs &As on the Increased Medicaid Payment for Primary Care
CMS 2370-F - MANAGED CARE**

What federal match rate is available to the states for administrative costs incurred from implementation of this rule?

The regular administrative federal match rate is applicable to administrative costs associated with implementation of this rule. Section 1905(dd) of the Social Security Act (the Act) authorizes increased FMAP only for eligible services provided by eligible providers pursuant to section 1902(a)(13)(C) of the Act.

Primary Care Services under Managed Care Delivery Systems

The requirements under 42 C.F.R. 438.804 specify that the states submit two methodologies to CMS for review and approval to implement this rule. How does approval of these methodologies impact the approval process for managed care contracts and rate packages for 2013?

Implementing regulations at 42 CFR 438.804 require states to submit to CMS a methodology for calculating the July 1, 2009 baseline rate for eligible primary care services and a methodology for calculating the rate differential eligible for 100% FFP by March 31, 2013. Further, 42 CFR 438.6 (c)(5)(vi) establishes MCO, PIHP or PAHP contract requirements to comply with this provision. It is CMS's expectation that as soon as practicable after the State submits the required methodologies in 42 CFR 438.804 and receives CMS approval, the State will:

1. submit revised actuarial certification documents reflecting the Medicare rate for eligible primary care services in their MCO, PIHP or PAHP capitation rates; and
2. submit amendment(s) to this contract to ensure compliance with 42 CFR 438.6 (c)(5)(vi).

After CMS approval of the revised contract and rates, the MCO, PIHP or PAHP must direct the full amount of the enhanced payment to the eligible provider to reflect the enhanced payment effective January 1, 2013. Federal financial participation (FFP) is available at a rate of 100% for the portion of capitation rates attributable to these enhanced payments; however, receipt of the enhanced FFP is contingent upon the state's successful completion of this process.

Can managed care plans under contract with a state use their own definitions of primary care providers and services for purposes of complying with this rule?

While we recognize that health plans may have unique definitions of primary care providers and services, the availability of the increased FMAP is limited to the scope of eligible primary care providers and primary care services as defined in statute and implemented by this rule.

Are bonus payments and other incentive arrangements for health plans included in the methodology for determining the rate differential that is eligible for 100% FFP?

We addressed the treatment of bonus payments and other incentive arrangements in terms of

identifying the 2009 base rate in the final rule and take this opportunity to clarify that such arrangements are similarly excluded from the methodology for determining the rate differential.

Is the relevant Medicare rate both the ‘floor’ and ‘ceiling’ for health plan payments to eligible providers for eligible services?

The applicable Medicare rate does effectively become the ‘floor’ for payments to eligible providers for eligible services, but not the “ceiling.” Health plans may pay above that rate depending on their specific contractual arrangements with providers.

Will Medicaid health plans be required to pay eligible providers the higher rate prior to receiving payment from the State for the higher rate?

While some plans may be able to pay the higher rate prior to receiving state funds, the final rule does not obligate a health plan to pay eligible providers the higher rate until they have been provided the funds to do so.

Will retroactive provider payments by health plans - necessitated by the State’s retroactive payment of the higher rates to health plans - be subject to timely claims filing requirements in 42 CFR 447.46? If so, may States impose liquidated damages or other penalties on health plans for violating those requirements?

Any retroactive payments made to providers in order to ensure that eligible providers receive the applicable Medicare rate for eligible services will not be considered claims subject to the requirements in 42 CFR 447.46.

When will CMS provide standardized contract language reflecting the requirements of this provision as mentioned during the All-State Call on November 8th?

CMS will be working collaboratively with the National Association of Medicaid Directors (NAMd) to develop the contract elements necessary to reflect the requirements of this rule. In recognition of the State Medicaid Agency’s role in the contracting practice, CMS will describe the suggested content areas rather than issue standardized contractual language. These elements will be described in further detail in a future Q&A document.

How will states with Medicaid managed care programs comply with the requirement to report provider participation levels specified in 42 CFR 447.400(d)(1)?

At this time, CMS is not defining the form of information required under 42 CFR 447.400(d)(1), but we do suggest that states with Medicaid managed care programs conduct a baseline assessment of primary care access before the provision goes into effect. This baseline assessment will ensure that Congress, CMS, and researchers have comparative data to evaluate this provision.

Qs &As on the Increased Medicaid Payment for Primary Care CMS 2370-F

When will states begin making higher payment for Evaluation and Management services reimbursed fee for service?

Effective for dates of service on and after January 1, 2013 through December 31, 2014, states are required by law to reimburse qualified providers at the rate that would be paid for the service (if the service were covered) under Medicare. Most states and the District of Columbia will need to submit a Medicaid state plan amendment (SPA) to increase Medicaid rates up to this level. CMS has issued a SPA preprint for the purpose of expediting review and approval of the primary care payment increase.

For dates of service starting January 1, 2013 qualified providers are entitled to receive the higher payment in accordance with the approved Medicaid state plan amendment. . States may not have attestation procedures or higher fee schedule rates in place on January 1, 2013. In that event, providers will likely continue to be reimbursed the 2012 rates for a limited period of time. Once attestation procedures are in place and providers are identified as eligible for higher payment, the state will make one or more supplemental payments to ensure that providers receive payment for the difference between the amount paid and the Medicare rate. Qualified providers should receive the total due to them under the provision in a timely manner.

A state may draw federal financial participation for the higher payments only after the SPA methodology is approved.

Which Medicaid providers qualify for payment?

Can physicians qualify solely on the basis of meeting the 60 percent claims threshold, irrespective of specialty designation?

Would a Board certified “general surgeon” qualify for higher payment if he or she actually practices as a general practitioner?

The statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. Under the regulation , “general internal medicine” encompasses internal medicine and all subspecialties recognized by the ABMS, ABPS and AOA. In order to be eligible for higher payment :

- 1) Physicians must first self-attest to a covered specialty or subspecialty designation.

- 2) As part of that attestation they must specify that they either are Board certified in an eligible specialty or subspecialty and/or that 60 percent of their Medicaid claims for the prior year were for the E&M codes specified in the regulation. It is quite possible that physicians could qualify on the basis of both Board certification and claims history.

Only physicians who can legitimately self-attest to a specialty designation of (general) internal medicine, family medicine or pediatric medicine or a subspecialty within those specialties recognized by the American Board of Physician Specialties (ABPS), American Osteopathic Association (AOA) or American Board of Physician Specialties (ABPS) qualify.

It is possible that a physician might maintain a particular qualifying Board certification but might actually practice in a different field. A physician who maintains one of the eligible certificates, but actually practices in a non-eligible specialty should not self-attest to eligibility for higher payment. Similarly, a physician Board certified in a non-eligible specialty (for example, surgery or dermatology) who practices within the community as, for example, a family practitioner could self-attest to a specialty designation of family medicine, internal medicine or pediatric medicine and a supporting 60% claims history. In either case, should the validity of that physician's self-attestation be reviewed by the state as part of the annual statistical sample, the physician's payments would be at risk if the agency finds that the attestation was not accurate.

The Affordable Care Act specifies increased payments for three primary care medical specialties: Family Medicine, General Internal Medicine and Pediatrics. The Final Rule interprets this language to include some subspecialties with a relation to the original three, but does not list the subspecialties. Please identify the subspecialists eligible for higher payment.

Subspecialists that qualify for higher payment are those recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS) or American Osteopathic Association (AOA). For purposes of the rule, "General Internal Medicine" encompasses "Internal Medicine" and all recognized subspecialties. The websites of these organizations currently list the following subspecialty certifications within each specialty designation:

ABMS

Family Medicine – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine

Internal Medicine – Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Geriatric Medicine; Hematology; Hospice and Palliative Medicine; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Sleep Medicine; Sports Medicine; Transplant Hepatology.

Pediatrics – Adolescent Medicine; Child Abuse Pediatrics; Developmental-Behavioral

Pediatrics; Hospice and Palliative Medicine; Medical Toxicology; Neonatal-Perinatal Medicine; Neurodevelopmental Disabilities, Pediatric Cardiology; Pediatric Critical Care Medicine; Pediatric Emergency Medicine; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology, Pediatric Transplant Hepatology; Sleep Medicine; Sports Medicine.

AOA

Family Physicians – No subspecialties

Internal Medicine – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Disease; Pulmonary Diseases; Nephrology; Oncology; Rheumatology.

Pediatrics – Adolescent and Young Adult Medicine, Neonatology, Pediatric Allergy/immunology, Pediatric Endocrinology, Pediatric Pulmonology.

ABPS

The ABPS does not certify subspecialists. Therefore, eligible certifications are: American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine. There is no Board certification specific to Pediatrics.

Is self-attestation required or may a state rely solely on information about Board certification gathered upon provider enrollment or data on a physician's MMIS claims history to determine eligibility for this payment?

The rule requires that physicians first self-attest to an eligible specialty or subspecialty and then attest to either Board certification or an appropriate claims history. States cannot pay a physician without evidence of self-attestation.

Does the 60 percent threshold include both E&M codes and vaccine administration codes?

Yes. The 60 percent threshold can be met by any combination of eligible E&M and vaccine administration codes.

The American Board of Physician Specialties does not certify subspecialists. Which Board certifications would qualify a physician for higher payment?

Physicians who are Board-certified by the ABPS in Internal Medicine, Family Practice, or Family Medicine Obstetrics would qualify for higher payment.

Physicians with a certification in Family Medicine Obstetrics are all certified first in family medicine with additional certification in obstetrics. They practice as family practitioners and are

therefore able to self-attest to a qualified specialty. This is not true of individuals certified in obstetrics by either the ABMS or AOA who do not qualify for higher payment.

Can a physician self-attest to Board certification or a supporting claims history after January 1, 2013, when the primary care payment increase begins but expect higher payment back to the beginning of the year?

States must have the appropriate self-attestations in hand before they can pay physicians at the higher rate. States can impose reasonable requirements regarding “retroactive” self-attestations to facilitate program administration. For example, a state could limit retroactive payments to the beginning of the month or quarter in which the attestation is submitted. However, physicians must be made aware of the payment provision and of the requirements concerning self-attestation before January 1, 2013 through state provider bulletin or manual systems or other mechanisms.

May a state automate its process for identifying qualified providers?

Yes. A state may automate its process for identifying physicians that qualify for this payment provided the process is transparent and legally binding. A state may not rely on a physician’s taxonomy in place of self-attestation to Board certification or a supporting claims history.

At the end of CYs 2013 and 2014 the Medicaid agency must review a statistically valid sample of physicians who self-attested either to Board certification or a supporting claims history to determine the validity of the data.

How will CMS ensure that only eligible providers receive the higher rate?

The final rule requires physicians to self-attest to an eligible specialty designation and to further indicate whether they are Board certified in an eligible specialty or subspecialty or 60 percent of the services for which they bill are for eligible E&M or vaccine administration codes. Annually, states must conduct a review of a statistically valid sample of physicians that have self-attested to either Board certification or a supporting claims/service history. Physicians and State Medicaid agencies must keep all information necessary to support an audit trail for services reimbursed at the higher rate.

If the sampled data indicates the inclusion of non-qualified providers should repayment be based upon data for all physicians who received higher payment or only the sampled providers?

CMS will require that the state repay erroneous payments found through the sampled pool of providers, and will not extrapolate data from the sample to the entire universe of physicians who received the higher primary care payment. States with high error rates should submit a plan for corrective action to reduce errors.

Can mid-level/non physician practitioners such as nurse practitioners receive the higher payment?

The final rule specifies that services must be delivered under the Medicaid physician services benefit. This means that higher payment also will be made for primary care services rendered by practitioners working under the personal supervision of a qualifying physician. The rule makes clear that, while deferring to state requirements regarding supervision, the expectation is that the physician assumes professional responsibility for the services provided under his or her supervision. This normally means that the physician is legally liable for the quality of the services provided by individuals he is supervising. If this is not the case, the practitioner would be viewed as practicing independently and would not be eligible for higher payment.

How are case management fees in Primary Care Case Management (PCCM programs affected by this rule?

PCCM payments are not eligible for higher payment under this rule.

Do physicians practicing in FQHCS and RHCs qualify for higher payment?

Higher payment does not apply to services provided under another Medicaid benefit category such as clinic or Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

Will the new payment rate for each of the billing codes affected by this regulation be made publicly available?

Yes. This information will be made available on Medicaid.gov. States will be asked to verify the payment amount in effect for each of the billing codes affected by the final rule as of July 1, 2009.

Will CMS issue a preprint for the increased physician payment?

Yes. CMS has provided a preprint for the reimbursement section of the Medicaid state plan that will describe payment for evaluation and management services and vaccine administration. The preprint is available on Medicaid.gov.

Is a state required to cover all of the primary care service billing codes specified in the regulation and then reimburse all qualified providers at the Medicare rate in CYs 2013 and 2014?

A state is *not* required to cover all of the primary care service billing codes if it did not previously do so. Rather, to the extent that it reimburses physicians using any of the billing codes specified in the final rule, the state must pay at the Medicare rate in CYs 2013 and 2014.

Will a state receive 100 percent federal matching funds for new codes added to the fee schedule in CYs 2013 and 2014?

A state may not add any of the eligible service codes solely for the purpose of obtaining enhanced federal matching funds. For example, a state may not eliminate a code currently in use and attempt to substitute it with another E&M code.

However, we recognize that a handful of codes have been added to the E&M code set since 2009. States which added those codes to their fee schedules will receive higher match for those services.

The NPRM provided that states were required to pay the lesser of the provider's charges or the applicable Medicare rate. The final rule no longer specifies this. Can a state continue to pay at the lower of the two amounts?

Under Medicare and Medicaid principles, payment is to be made at the lower of provider charges or the rate, which in this case is the applicable Medicare rate. This language was inadvertently omitted from the final rule. CMS is processing a technical correction to the regulatory text at 42 CFR 447.405 to restore this language.

Does higher payment apply to CHIP?

The primary care provider rate increase does apply to CHIP Medicaid expansions but not separate (stand-alone) CHIPs. Qualified physicians who render the primary care services and vaccine administration services specified in the regulation will receive the benefit of higher payment for services provided to these Medicaid beneficiaries.

The State will receive 100 percent federal matching funds for the difference between the rate in effect 7/1/09 and the rate in CYs 2013 and 2014. The remainder of the payment will be funded at the CHIP matching rate, through the CHIP allotment. Services provided under separate (stand-alone) CHIPs are not eligible for higher payment.

The rule indicates that all limitations, conditions and policies that applied to the code prior to January 1, 2013 can be applied to the code after that date. If a state sets a reduced rate for a Level III emergency service (99283) if it is a triage service (based on criteria described in the state plan) can it continue to do so or must it pay 100 percent of the Medicare rate? If it can continue to reduce the rate, must it develop a "Medicare triage rate", or can it continue to use the Medicaid triage fee?

This rule does not affect the state's ability to define and operate its coding system, and a state could distinguish claims submitted from those otherwise identified with code 99283. For those claims, the state should develop a rate that it believes Medicare would pay if Medicare made a similar distinction for emergency services limited to triage services, and would then pay that rate. For claims that were not limited to triage services, the state would pay based on the established Medicare rate for code 99283.

What federal matching rate will apply for services for which a higher payment is made under this rule, if the services also qualify for a higher FMAP under the provisions of section 4106 of the Affordable Care Act?

In qualifying states, certain United States Preventive Services Task Force (USPSTF) grade A or B preventive services and vaccine administration codes are eligible for a one percent FMAP increase under section 4106 of the Affordable Care Act (which amended sections 1902(a)(13) and 1905(b) of the Act). Some of these services may also qualify as a primary care services eligible for an increase in the payment rates under section 1202 of the Affordable Care Act. For these services the federal matching rate is 100 percent for the difference between the Medicaid rate as of July 1, 2009 and the payment made pursuant to section 1202 (the increase). The federal matching payment for the portion of the rate related to the July 1, 2009 base payment would be the regular FMAP rate, except that this rate would be increased by one percent if the provisions of section 4106 of the Affordable Care Act are applicable.

Primary Care Services and Vaccine Administration

How will States and providers know which primary care services will be paid at the higher rate?

The regulation at 42 CFR 447.000(c)(1) and (2) specifies Evaluation and Management codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473, or their successor codes.

What will the reimbursement rate be for those E&M codes that Medicare does not cover?

The final rule provides that CMS will use develop reimbursement values based on the formula used to set Medicare rates. We will make this information available through Medicaid.gov.

How will vaccine administration be paid for services vaccines provided under the Vaccines for Children (VFC) program?

As specified at 42 CFR 447.405(2)(b) for vaccines provided under the Vaccines for Children Program (VFC) in CYs 2013 and 2014, a state must pay the lesser of: (1) the Regional Maximum Administration Fee; or, (2) the Medicare fee schedule rate in CY 2013 or 2014 (or, if higher, the rate using the 2009 conversion factor and the 2013 and 2014 RVUs) for code 90460.

This complies with the statutory requirements of the VFC program that limit payments to the VFC ceiling, which is the amount charged by the provider, and to one payment per vaccine administered regardless of the number of antigens in the vaccine. In 2013 and 2014, CMS expects that the regional VFC ceilings will be lower than the Medicare rates, which will result in a payment increase to providers.