Healthcare 101: Medicaid Primary Care Payment under The Affordable Care Act

Background
Medicaid, the largest public health insurance program in the United States, covers over 60 million low-income individuals. The federal government and states share the cost of Medicaid, with states receiving varying contributions from the federal government based on the Federal Medical Assistance Percentages (FMAP). State Medicaid agencies govern the program and therefore the benefits and cost sharing for beneficiaries and payments to providers can vary across states.1

Many of the provisions within the Affordable Care Act (ACA) sought to increase health care coverage; however, there have been concerns that newly Medicaid-eligible individuals will have difficulty accessing primary care physicians. A study completed by an economist at the Centers for Disease Control (CDC) determined that one third of physicians would not take new Medicaid patients in 2011. Research suggests that low payment rates are the main factor preventing physicians from participating in Medicaid.2 In 2012, Medicaid fees for primary care services averaged 59% of Medicare fees (down from 66% in 2008) and in states with large Medicaid enrollment, the ratio in 2012 was less than 50%.3

In order to improve access to primary care for Medicaid beneficiaries, the ACA included a provision to increase payments to the Medicare level for certain Medicaid primary care services for the years 2013-2014.4

Federal Guidance
On November 6, 2012, the Centers for Medicare & Medicaid Services (CMS) published the final regulation related to the implementation of the Medicaid primary care rate increase. For the years 2013 and 2014, eligible physicians who provide certain primary care services under Medicaid will be paid at Medicare rates for two years for those services.

In addition to the final rule, CMS has released a series of Q&A guidance:

- Q&A: Increased Payments for PCPs
- Q&A Set II: Increased Payments for PCPs
- Q&A Set III: Increased Payments for PCPs
- Q&A Managed Care: Increased Payments for PCPs

On January 30, 2013, CMS released technical guidance to assist State Medicaid agencies in establishing methodologies for incorporating into Medicaid managed care capitation rates.

Who is Eligible? Family physicians, internists and pediatricians (as well as some subspecialists) qualify for the higher Medicaid fees if they attest that they are board-certified or that at least 60% of the Medicaid codes they billed in the previous year were primary care codes identified in the ACA. Midlevel practitioners, such as physician assistants, are eligible for the enhanced payments, provided they are supervised by physicians who also qualify for the increase.

What Services are Eligible? The ACA identified 146 primary care services that qualify for the increased payment. The increases will not apply to federally qualified health centers and rural health clinics.

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4 Patient Protection and Affordable Care Act, Section 1202, Public Law 111-152, 11th Cong. (March 2010)
Who Pays for Increased Payment? The federal government will fund the full cost of the fee increase, up to the difference between Medicaid fees as of July 1, 2009 and Medicare fees in 2013 and 2014. The estimated federal cost of the pay increase is $11.9 billion over two years. States will have flexibility in administering the increased payment as they can provide the fee as add-ons to the existing rate or as lump sum payments (if provided at least quarterly).

What about Managed Care Organizations? The ACA requires that qualified physicians in Medicaid Managed Care Organizations (MCOs) also receive the full benefit of the fee increase, whether the MCO pays them on a fee-for-service, capitation or other basis. States have flexibility in implementing this requirement, but they must submit methodologies for identifying what MCO payments to qualified physicians would have been for ACA primary care services as of July 1, 2009, and for identifying the portion of their 2013 and 2014 capitation payments attributable to the fee increase, for which the 100% federal match is available.5

What Actions are Necessary for States? The rule permits states to either “lock” rates at the level of the Medicare physician fee schedule in effect at the beginning of 2013 and 2014 or modify the rates in alignment with all updates by Medicare. States can pay the site-specific Medicare fee amount for a service or, instead, always pay the Medicare office rate regardless of the actual site of service. It also permits states to either pay in accordance with all Medicare locality adjustments within the state or to develop a rate for each code based on the mean Medicare rate over all counties in the state to be paid on a statewide basis. States must submit a state plan amendment to reflect the higher Medicaid payment rates in 2013 and 2014 unless they already pay at least the Medicare rate for every eligible primary care code. CMS has stated they will provide a State Plan Amendment (SPA) template to assist states which needs to be submitted by March 31, 2013.

Implications for Molina Healthcare
MCOs are not required to make enhanced payments until the state plan amendment is approved; they are paid by the state to pay the increase and a contract amendment reflecting increased payment is issued. CMS has stated that retroactive payments made by MCOs to comply with this requirement will not be subject to timely claims payment and interest requirements.

Key Considerations
- The federal government will pay 100% of the cost of increase in payment to providers for two years but funding is unclear should the provision be extended. Physician groups have already begun a lobbying effort to get the increased payment extended.
- Certain physician groups have concerns that not all subspecialists are eligible for the increased payments. For example, some beneficiaries use their obstetrician/gynecologist or oncologist as their primary care physician – all of which would be ineligible for the increased payment for primary care services. To address this issue, some providers have proposed all evaluation and management services codes be eligible for the increased payments.
- The Medicaid and CHIP Payment and Access Commission (MACPAC) has expressed concerns that due to the complexity of Medicaid payments and multiple changes happening at the same time, it could be difficult to get clarity as to the overall result of the pay increase.6

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