CHCS Center for Health Care Strategies, Inc.

Technical Assistance Tool

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

MARCH 2011

The Affordable Care Act's (ACA) expansion of Medicaid eligibility to 16-20 million new beneficiaries beginning in 2014 may generate additional 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 100% by the federal government.[1]

The increased reimbursement could be a powerful tool for bolstering the delivery system, enhancing access to, 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 expanding the number of PCPs in the Medicaid network; increasing access and quality measurement efforts; and implementing changes to the provider fee schedule, contracts, and FMAP reporting processes.

Implementing Medicaid Primary Care Rate Increases: A Roadmap for States is designed to guide states through the planning and implementation process. The roadmap on the following pages can help states: (1) understand critical parameters of the increase; (2) identify the operational steps 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.

As of early March 2011, CMS has yet to provide states with regulatory guidance, but will do so in the near future. Even in the absence of such regulations, states can make substantial progress in preparing and planning for implementation. For example, states can analyze and compare fee schedules and service codes, assess MMIS capabilities, engage stakeholders, and develop strategic plans to leverage the policy opportunities. This roadmap is designed to assist states with these tasks. As CMS publishes regulatory guidance, the roadmap will be updated.

Background

This roadmap is a product of *Increasing Primary Care Rates, Maximizing Medicaid Access and Quality*, a Center for Health Care Strategies (CHCS) initiative made possible through support from The Commonwealth Fund. CHCS is working with Medicaid stakeholders, including the Centers for Medicare & Medicaid Services (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.

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PRIMARY CARE RATE INCREASE IMPLEMENTATION: A ROADMAP FOR STATES		
Key Implementation Steps	***Why Important***	***Tasks to Complete***
1) Identify the primary care services covered in the Section 1202 rate increase.	Section 1202 covers specific Evaluation and Management (E&M) codes and immunization services. States will only receive increased payments for those services and will need to program their systems appropriately.	✓ Create a crosswalk of the primary care codes currently used by Medicaid and the Medicare E&M codes eligible for increased reimbursement, as specified in Section 1202. Assess and address gaps.
2) Identify the eligible provider types and places of service.	The primary care increase only applies to specific providers: family medicine, general internal medicine, and pediatric medicine. The increase does not apply to physician extenders such as nurse practitioners and physician assistants, or to specialties like OB/GYNs. Medicare primary care rates vary depending on where the service is provided, e.g., in a physician's office or at a facility. Medicare rates vary by region within a state, so states may need to incorporate regional variation into their fee schedule, depending on CMS guidance.	✓ Determine 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 and to the appropriate Medicare place of service categories. ✓ 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 on your state.

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3) Understand the baseline primary care rates for fee-for-service (FFS) and managed care as of July 1, 2009.	The federal match is based on the difference between a state's primary care rates in place on July 1, 2009, and the Medicare rates in place at the time of service. States must access their FFS fee schedules as of that date in order to calculate the size of the rate increase. States must also understand the primary care rate base that was used as of July 1, 2009, to calculate the capitated payments to Medicaid health plans. Understanding this differential is necessary for calculating the PCP federal matching revenue, which will be reported to CMS separately from other services eligible for the federal match rate currently in place. It is also necessary for recruiting new physicians, communicating with the existing network, and tracking expenditures over time.	✓ 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.

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4) Adjust the rates for eligible primary care services: – FFS fee schedule – Managed care capitated payments	The payment logic embedded within in the new fee schedule varies from the way that states currently pay claims. States may need to modify their MMIS systems to accept a new fee schedule and incorporate new payment logic. States must also incorporate the new rates into their actuarial models in order to adjust capitated payments to managed care organizations (MCOs).	✓ Evaluate whether MMIS payment logic can accommodate fee schedules which 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 MCO. Also consider the degree to which the MCOs include Federally Qualified Health Centers in their network, which are not eligible for the rate increase.

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5) Modify FMAP calculation and reporting.	The federal matching rate for the PCP increase varies from the matching rate currently in place for a state's Medicaid expenditures. CMS will require states to separately report the differential expenditures stemming from the rate increase. Calculating the expenditure differential associated with primary care services in managed care will be particularly difficult.	✓ 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.

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6) Recruit new providers and maintain the primary care network.	A larger provider network may be necessary to accommodate the increased number of Medicaid beneficiaries. The rate increase provides a potentially powerful recruitment tool, especially for states with rates substantially below Medicare payment levels. The increase can also help maintain participation rates of providers currently accepting Medicaid patients and encourage them to accept new patients. Improving operational processes that impact providers, like physician payment timeliness, adjudication processes, and patient eligibility verification, can also promote network expansion and maintenance.	✓ 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. ✓ Begin to assess areas such as claims documentation requirements and patient verification processes and identify opportunities to streamline those processes for physicians.
7) Expand quality and access measurement.	The rate increase creates an opportunity to expand access and quality measurement to support delivery of high quality care. While Medicaid frequently establishes such standards with its health plans, these requirements are often not directly in place between Medicaid and FFS PCPs.	✓ 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 – Identify key utilization measures that may be impacted by the rate increase.

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8) Implementing advanced primary care payment methodologies.	The rate increase may be incorporated into advanced payment methods that go beyond FFS.	✓ Assess your state's predominant payment models and readiness for or interest in implementing advanced payment methods such as care management payments, incentive payments, capitated/global payments for medical home services, or episode-of-care/bundled payments. ✓ Estimate the anticipated amount of increased primary care expenditures your state is interested in distributing via advanced payment methodologies.
9) Measure the impact of the increase.	With the PCP rate increase funded for only two years, states will need to "make the case" for sustaining that increase beyond 2014. A valid program evaluation of the increase's impact will be an important component of the sustainability discussion.	✓ Identify key measures that you anticipate will be impacted, such as: – Access (e.g., Number of patients per PCP, Access to 1st-3rd appointment time, Patient satisfaction for timeliness of primary care) – Quality (e.g., HEDIS measures) – Utilization (e.g., ED utilization, Readmissions) ✓ Develop a program evaluation plan to measure the impact of the increase on patient access to primary care and utilization of unnecessary services. ✓ Calculate 2012 Medicaid baseline rates for the core measure set.

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 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, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.