

**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 CFR 438.804 specify that the states submit two methodologies to the Centers for Medicare & Medicaid Services (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 percent of Federal Financial Participation (FFP) by March 31, 2013. Further, 42 CFR 438.6 (c)(5)(vi) establishes Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (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 percent 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 percent 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  
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**May States delegate the self-attestation process to their contracted managed care plans?**

Yes. A state may elect to delegate the self-attestation process to its contracting health plans under the following circumstances:

1. Each managed care plan has signed documentation on file (provider contract or credentialing application) from the eligible provider attesting to the fact that he or she has a covered specialty or subspecialty designation. This addresses step 1 of the 2-step self-attestation process specified in the rule.
2. The managed care plan has verification of the provider's appropriate Board certification (as part of the credentialing and re-credentialing process). This addresses one option of the 2nd step in the self-attestation process.
3. Should Board certification in the eligible specialty not be able to be verified by the managed care plan, the eligible provider must provide a specific attestation to the managed care plan that 60 percent of their Medicaid claims for the prior year were for the HCPCS codes specified in the regulation. This addresses a second option for the 2nd step in the self-attestation process.
4. Such delegation is included in the contract amendment that is otherwise being filed to implement this provision.

**Are eligible E&M and vaccination codes that are covered by managed care health plans but not under the Medicaid State plan eligible for reimbursement at the enhanced Medicare rate?**

No. The only codes that are eligible for reimbursement at the Medicare rate as specified under the final rule are those eligible codes that are identified under the Medicaid State plan. Additional E&M or vaccination administration codes that are being "covered" by a health plan but that are not identified in the state plan cannot be reflected in the rates.

**The final rule specified that states will need to recoup the enhanced payments made to non-eligible providers identified through the annual statistically valid sample. Must health plans follow the same procedure for non-eligible providers?**

States must require health plans to recoup erroneous payments found through the sampled pools of providers, and in a number of states, this sample will include both FFS and managed care providers.

**Are MCOs permitted to include amounts sufficient to account for the payment differential on expected utilization while still holding the sub-capitated primary care physicians at risk for some level of increase in utilization due to the higher rates? Or must MCOs remove the risk to primary care physicians for utilization to ensure that these physicians receive the increased amount for actual experience?**

The purpose of section 1202 of the Affordable Care Act and the final rule is to ensure access to and utilization of beneficial primary care services. Towards that goal, eligible primary care physicians must receive the full benefit of the enhanced payment at the Medicare rate for eligible services rendered. If a Medicaid managed care health plan retains sub-capitation arrangements, the health plan would be obligated to provide additional payments to providers to ensure that every unit of primary care services provided is reimbursed at the Medicare rate.

**May states continue to use discounted reimbursement rates for out-of-state or out-of-network eligible primary care providers, which may be less than the Medicare rate, for CYs 2013 and 2014?**

CMS acknowledges the customary practice of reimbursing out-of-state or out-of-network providers at a base rate minus a defined percentage. As provided in an earlier Q&A, the applicable Medicare rate effectively becomes the 'floor' for payments to eligible providers for eligible services rendered in CYs 2013 and 2014. Health plans may pay above that rate but not below.