AMERICAN HEALTH LAWYERS ASSOCIATION

PRACTICE GROUP email alert

Date: April 16, 2014

Medicaid Primary Care Provider Payment Increases and Related Considerations

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Many health care attorneys are increasingly receiving client inquiries regarding the enhanced Medicaid payments to qualified primary care providers under Section 1202 of the Affordable Care Act (ACA). Fortunately, the federal government has shared guidance to assist those who are working to understand the parameters surrounding these incentives and the related requirements. This guidance includes the manner in which such funds must be distributed directly to the rendering providers. This email alert serves as a starting point for those of us who may need to address these issues in our practice by providing a broad overview of the incentive program and links to certain key resources.

Purpose and Establishment of Enhanced Payments

Section 1202 of the ACA requires that state Medicaid programs increase payments to qualified primary care physicians for certain primary care services provided during 2013 and 2014. More specifically, Section 1202 requires state Medicaid agencies to pay providers at least the Medicare rates in effect for calendar years 2013 and 2014 for specified primary care services provided by physicians with a specialty designation of family medicine, general internal medicine, pediatric medicine, or certain subspecialties. The federal government will provide states with 100% federal matching funds for the increase in payments.

Regulations and Related Guidance

The Centers for Medicare & Medicaid Services (CMS) Final Rule implementing Section 1202 was issued during 2012. In response to questions from the state Medicaid programs and industry stakeholders regarding the implementation of Section 1202, CMS published helpful guidance, including an abundance of questions and answers (Q&As), to assist in applying its provisions. Additional guidance for providers is available from the state Medicaid agencies. The federal government expects the states to implement Section 1202 (and the regulations promulgated under such law) in a manner that advances the underlying goals of the payment enhancement, such as incentivizing providers to

choose primary care as a specialty, increasing the number of primary care physicians that participate in the Medicaid program, and better serving the Medicaid population through increased access to care as well as continuity and coordination of care.

Eligibility

In order to receive the enhanced Medicaid payments for primary care services under Section 1202, physicians must self-attest to a specialty designation of family medicine, general internal medicine, and pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, American Board of Physician Specialties, or the American Osteopathic Association. As part of that attestation, the physician must specify that they are either board certified in an eligible specialty or subspecialty and/or that 60% of the Medicaid claims for the prior year were for the evaluation and management and vaccine administration codes specified in the Final Rule. Each state agency is required to develop its own attestation form, and physicians are encouraged to contact the applicable state agency for additional information regarding the process for becoming eligible for such payments.

Distribution of Payments

The federal government has clarified that physicians must receive the direct benefit of the enhanced payments under Section 1202. The preamble to the Final Rule states: "[t]his requirement must be met regardless of whether a physician is salaried, or receives a fee for service or capitated payment. We emphasize that increased payment must correspond directly to the volume and payment amounts associated with the primary care services specified in this rule." CMS issued guidance in the Final Rule and Q&As with respect to the manner in which the direct benefit requirement must be satisfied and the state Medicaid program responsibilities in such regard.

Potential for Audits

The Final Rule provides that, on an annual basis, state Medicaid agencies will be required to conduct a review of a statistically valid sample of physicians that have self-attested to either board certification or a qualifying claims/service history. Accordingly, physicians and state Medicaid agencies must retain all documentation required to support an audit trail for services reimbursed at the higher rate.

**We would like to thank Kathryn Hickner-Cruz (Dresevic Gustafson Iwrey Kalmowitz and Pendleton Law Group, a Division of The Health Law Partners PC, Cleveland, OH) for providing this email alert.*

Member benefit educational opportunity:
Participate in Part III of the personalized medicine bootcamp: regulatory oversight of genetic products and services (April 23).