

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

**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.