CMS Finalizes Medicaid Primary Care Payment Rule Affecting Dual Eligibles

CMS has finalized a rule that will pay Medicaid primary care physicians at the same rate as Medicare in 2013 and 2014, a move that is likely to improve access to care for individuals who received both Medicare and Medicaid services (dual eligibles).

On Friday, November 2, CMS announced the final rule, 42 CFR Part 438, 441, and 447, which specifies that federal funding will be provided to states to increase payments to physicians who specialize in family medicine, general internal medicine or pediatric medicine. CMS will provide a 100% federal contribution, or Federal Financial Participation, for the increased physician payment.

The rule centers on implementing §1905(dd) of the Affordable Care Act (ACA), which allows states to receive enhanced funding equal to the difference between the state’s Medicaid rate for primary care services in 2009, and the Medicare primary care rate for 2013 and 2014.

Impact on dual eligible individuals

CMS was careful to point out that the enhanced payment requirement applies to services provided to individuals who receive both Medicare and Medicaid Services (dual eligible individuals). Currently, while states are obligated to cover the Medicare cost sharing of dual eligibles (including both full benefit dual eligibles and Qualified Medicare Beneficiaries), states are allowed to limit their obligation to the amount they would pay for the same service under the state’s Medicaid rate.

For example, a dual eligible receives services from a Medicare provider for which the Medicare approved rate is $100, but the state’s Medicaid rate is just $75. Medicare pays $80 (80% of the Medicare rate) and the state Medicaid agency pays nothing since the Medicaid rate for the service is less than the amount Medicare has already paid. The enhanced payment would provide federal funding to make up the difference.

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1 The final rule is available here: [www.ofr.gov/OFRUpload/OFRData/2012-26507_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2012-26507_PI.pdf).
2 The final rule implements §§1902(a)13, 1902(jj), 1932(f) and 1905(dd) of the Social Security Act, as Amended by the Affordable Care Act (Pub. L. 111-148 and 111-152). CMS received 171 comments from states, advocacy groups, health care providers, employers, health insurers, health care associations, and citizens.
3 Final rule at 50.
provider is left with the $80 payment from Medicare and is prohibited from pursuing the additional $20 from the beneficiary.

Advocates report that, because of these payment gaps, many Medicare providers refuse to serve Qualified Medicare Beneficiaries (QMBs). A 2003 study commissioned by CMS confirmed the problem of provider access, particularly with primary care providers and mental health professionals.

Under the new rule, Medicaid programs will be required to reimburse qualified physicians up to the full Medicare rate. In the scenario described above, the provider will receive a $20 payment from the Medicaid program.

Advocates indicated enthusiastic support for the application of this rule to dual eligibles and are pleased that it is part of the final rule. Dual eligibles often experience difficulty finding providers willing to see them, since doing so essentially means the providers will only receive 80% of the Medicare rate. This new rule, will make dual eligibles like other Medicare beneficiaries in the eyes of providers, likely increasing access to providers for dual eligibles as a result.

**States with low rates after 2009**

Many of the states have lowered their Medicaid physician payment rates since 2009. These states must still comply with the new requirement; however, they will only receive the enhanced federal match for the difference between their 2009 rate and the 2013 and 2014 rates. States will be reimbursed at their regular federal match rate for the amount between the states current Medicaid rate and their 2009 rates.

**Managed Care Organizations**

The final rule clarifies that the new requirement applies to Medicaid managed care programs. Under the rule, managed care organizations (MCOs) will be required to pay their physicians these higher rates.

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5 See Janet B. Mitchell and Susan G. Haber, “State Payment Limitations on Medicare Cost-Sharing Impacts on Dually Eligible Beneficiaries and Their Providers” (July 2003), available at [www.rti.org/abstract.cfm?pid=1203](http://www.rti.org/abstract.cfm?pid=1203). Although the study proposed that CMS continue to monitor provider access, no later studies were commissioned.


7 Id.

8 Final rule at 9.
CMS recognized the challenge states have to identify their 2009 baseline for primary care services for managed care organizations and agreed to grant states some flexibility in making this determination. States are required to submit their methodology for determining these 2009 baselines to CMS by April 1, 2013 and the methodology must be approved by CMS.\(^9\)

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\(^9\) Final rule at 55.