

Medicaid Managed Care Payment for PCP Services in 2013 and 2014

Technical Guidance and Rate Setting Practices

Section 1902(a)(13)(C) of the Social Security Act (SSA), as amended by the Affordable Care Act of 2010 (ACA), requires that state Medicaid programs incorporate the requirement for increased payment to primary care providers for 2013 and 2014 into contracts with managed care organizations and the corresponding capitation payments. States have flexibility to implement this provision using methodologies consistent with their current rate-setting practices. CMS expects that States will explain both how they intend to make funds available to their contracted managed care plans (MCPs) in order for providers to receive the increased payments as well as how they will calculate the amount of those funds eligible for 100% Federal Financial Participation (FFP). However, the states must provide documentation to CMS that the payments are based on reasonable data sources and assumptions and have their methodology approved. This document is intended to assist states in developing approvable methodologies for both determining the 2009 capitation payments attributable to these services and the amount of expenditures on eligible services for which the State can receive 100% match.

***Note:** Wording in italics comes directly from the Final Rule or the Comments and Response section of the rule as provided in the Federal Register.*

Background

Section 1902(a)(13)(C) of the SSA, as amended by the ACA, requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. Payment by state Medicaid agencies for primary care services administered by certain physicians must be at least as much as the greater of:

- The Medicare rates in effect in calendar years 2013 and 2014
- The rate that would be applicable using the calendar year 2009 Medicare physician fee schedule conversion factor (CF)

States will receive 100% FFP for the difference between the July 1, 2009 Medicaid state plan rates and the appropriate calendar year 2013 and 2014 rates as defined above. The minimum payment level applies to physicians whom can 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, the 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 percent of the Medicaid claims for the prior year were for the E&M and vaccine administration codes specified in the regulation.

Primary care services that qualify for increased payment designated in the Healthcare Common Procedure Coding System (HCPCS) are as follows:

- Evaluation and Management (E&M) codes 99201 through 99499
- Vaccine administration codes 90460, 90461, 90471, 90472, 40473, 40474, or their successor codes

States that do not expect to receive an enhanced payment are still required to submit documentation confirming to CMS that they do not have any populations eligible for the enhanced payment rates and the 100% FFP.

Item #	Legal Cite	Subject
Section 1 – Required Methodologies		
1.0	42 CFR Part 438, 441, and 447 II.A.5.	<p>§ 438.804 Primary care provider payment increases.</p> <p>(a) For MCO, PIHP or PAHP contracts that cover calendar years 2013 and 2014, FFP is available at an enhanced rate of 100 percent for the portion of the expenditures for capitation payments made under those contracts to comply with the contractual requirement under § 438.6(c)(5)(vi) only if the following requirements are met:</p> <p>(1) The state must submit to CMS the following methodologies for review and approval.</p> <p>(i) The state develops a reasonable methodology, based on rational and documented data and assumptions, for identifying the provider payments that would have been made by MCO, PIHP or PAHP for specified primary care services furnished as of July 1, 2009. This methodology can take into consideration the availability of data, and the costs and burden of administering the method, but should produce a reliable and accurate result to the fullest extent possible.</p> <p>(ii) The state develops a reasonable methodology, based on rational and documented data and assumptions, for identifying the differential in payment between the provider payments that would have been made by the MCO, PIHP or PAHP on July 1, 2009 and the amount needed to comply with the contractual requirement under § 438.6(c)(5)(vi). This methodology can take into consideration the availability of data, and the costs and burden of administering the method, but should produce a reliable and accurate result to the fullest extent possible.</p> <p>(2) The state must submit the methodologies in paragraphs (a)(1)(i) and (ii) of this section to CMS for review no later than the end of the first quarter of CY 2013.</p> <p>(3) CMS will use the approved methodologies required under this section in the review and approval of MCO, PIHP or PAHP contracts and rates consistent with § 438.6(a).</p> <p>States will be required to submit the methodology they intend to use to identify the increment of the capitation payment attributable to increased provider rates to CMS for approval by the end of the first quarter of calendar year 2013. The same methodology information will need to be provided by the end of the first quarter of calendar year 2014 if the methodology is changed for 2014. The methodology for 2013 should include the following components:</p> <ol style="list-style-type: none"> 1. The risk model (see Section 2 below) 2. The calculation of the 2009 base rate (see Section 4 below) 3. The calculation of the 2013 capitation rate (see Section 5 below) 4. The calculation of the differential that qualifies for 100% FFP (see Section 6 below) <p>Absent approval of its methodology from CMS, states will not be able to claim the enhanced Federal match for capitation payments to managed care plans.</p>
Section 2 – Risk Models		
2.0		<p>CMS has specified that the states have flexibility in determining the risk model used for the implementation of this provision. The states may use an approved model that is reasonable and thoroughly documented. Below are three models that would generally be considered reasonable and acceptable to CMS.</p>

2.1		<p><u>Model 1: Full risk prospective capitation</u> Under the full risk prospective capitation approach the states would calculate the 2013 or 2104 capitation rate, which includes assumptions for the payment of the specified primary care services at the increased rate. Thus, these rates would be inclusive of the appropriate enhanced rate. The states would pay the required capitation payment to MCPs prospectively and there would be no reconciliation.</p>
2.2		<p><u>Model 2: Prospective capitation with risk-sharing that incorporates retrospective reconciliation</u> Under the prospective capitation with risk-sharing and retrospective reconciliation approach, the state would pay the MCPs prospectively, but would also reconcile retrospectively. When calculating the prospective capitation rate, the states would follow a methodology similar to the full risk prospective capitation methodology outlined in Section 5 below. Thus, these rates would be inclusive of the enhanced rate.</p> <p>Actual encounter data, or other reasonable data as available, would be used to compare the expected costs for the specified primary care services to the actual costs. Based on the difference, a predefined reconciliation would then occur that could include risk-sharing corridors.</p> <p>For the retrospective reconciliation, states will have flexibility to choose a reconciliation method that is reasonable and consistent with historical procedures. The states will need to negotiate and agree upon the reconciliation process with each MCP. In addition, the reconciliation will need to be approved by CMS and documented thoroughly in the methodology. Some approaches could include:</p> <ul style="list-style-type: none"> • 100% true-up – A reconciliation is performed after the end of the capitation period allowing sufficient time for run-out. Based on the actual number of occurrences of the specified services payments between the state and MCP are made to reflect actual utilization experience. • Using a risk corridor of plus or minus a certain percentage, with reconciliation only occurring outside of the corridors – For example a risk corridor of +/- 2% may be put in place. If the actual value of the payments for the specified services is within +/- 2% of the expected value, no reconciliation payments are made. If the difference is outside of the +/- 2% then payments are made to reconcile the actual versus expected amounts outside of the +/-2% range.
2.3		<p><u>Model 3: Non-risk Reconciled Payments for Enhanced Rates</u> Under this method, for 2013, states would prospectively pay capitation rates without enhanced primary care payments. Thus, these capitation rates would not be inclusive of the enhanced rate. At agreed upon intervals (e.g., quarterly) the MCPs would summarize actual encounter data or another reasonable data source to calculate the total payment that eligible providers would need to be paid for eligible services in order to reach the mandated Medicare payment rates. The state would review this report and if found reasonable, the state would pay the MCP the calculated additional payment amount. The MCP would then distribute those payments to the primary care providers using a method of their choosing.</p>
2.4		<p>Although states are given flexibility to choose a reasonable risk sharing model, some models may be deemed to be unacceptable. For example, CMS will not allow direct payments from the state to an eligible provider for eligible primary care services that are covered under the state’s managed care contract with a MCP. Such direct payments are a violation of 42 C.F.R. 438.60 and thus, will not be permitted.</p>

Section 3 – Introduction to the detailed guidance

3.0	42 CFR Part 438, 441, and 447 II.A.5, II.A.4.c and II.B	<p><u>Calculation Methodology</u> <i>The state has the flexibility in determining the 2009 baseline rate and the rate differential to comply with this rule, but the approach taken must be based on reasonable and documented data sources available to the state to accurately define these amounts to the fullest extent possible. We will review and approve the methodologies and refer to these methodologies to approve MCO, PIHP and PAHP contract amendments and rates necessary to implement this rule. This rule does not require a specific method for the MCOs, PIHPs or PAHPs to make the enhanced payment for primary care services to eligible providers, but the approach taken must ensure that the eligible primary care provider receives the full benefit of the enhanced payment.</i></p> <p>CMS has specified that the states have flexibility in determining the 2013 and 2014 capitation rates, the 2009 baseline rate, the risk model and the rate differential to comply with the final rule. The states may use an approach that is actuarially sound and documented appropriately. The methodology selected by each state may depend on on the availability and reliability of data. In addition, the ability to collect information from MCPs to identify appropriate primary care providers and primary care services may also influence the state’s chosen methodology.</p> <p><u>Eligible Codes</u> <i>This rule requires state Medicaid agencies to reimburse at the applicable 2013 or 2014 Medicare rate for E&M codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 to the extent that those codes are covered by the approved Medicaid state plan or included in a managed care contract. The 2009 base rate for codes not covered in 2009 but subsequently added will be \$0.</i></p> <p>Any new covered E&M codes in 2013/2014 must be approved through the Medicaid State plan process; once they are approved, they are eligible for 100% FFP. If the state covers other E&M codes not specified in the regulations it is not eligible for the 100% FFP.</p> <p><u>Vaccine Administrative Payment</u> <i>Because the immunization administration codes changed in 2011, states will need to determine the payment amount from other codes based on service volume. The service volume of code 90465 and of the pediatric claims for code 90471 will need to be imputed to determine the new payment for code 90640.</i></p> <p><i>In addition, VFC providers will be reimbursed at the lesser of the 2013 and 2014 Medicare rates or the maximum regional VFC amount in those years.</i></p> <p>The calculation of the payment differential for vaccine administration codes differs from the E&M codes in the following ways:</p> <ul style="list-style-type: none">• For vaccines provided under the Vaccines for Children Program in CYs 2013 and 2014, a State must pay the lesser of:<ul style="list-style-type: none">○ The Regional Maximum Administration Fee (Regional Maximum Administration Fees by state can be found in section II.B of the final rule); or,○ The Medicare fee schedule rate in CY 2013 or 2014 (or, if higher, the rate using the 2009 conversion factor and the 2013 and 2014 RVUs) for code 90460• New code 90460 represents the initial vaccine/toxoid administered through all routes to children through age 18. The 2009 rate would equal the average payment amount weighted by volume of codes 90465 and 90471. Code 90465 was only for children
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younger than 8 years of age and code 90471 was used for children above age 8 prior to January 1, 2011. Therefore, claims volume for code 90465 and code 90471 are used to impute the payment amount in the base period for the current code 90460. The final rule gave the following example:

- 90465 = \$10 x 0.70 service volume = \$7.00
- 90471 = \$10 x 0.30 service volume = \$3.00
- Total cost equals \$10.00 for the new, single code, 90460
- Code 90461 represents payment for additional vaccines/toxoids administered. The 2009 value for code 90461 would be \$0, since there was no payment for additional vaccines/toxoids prior to 2011. VFC requires that there cannot be multiple payments for a single vaccine. As such, code 90461 will not yield an enhanced payment.

Codes not Covered by Medicare

For codes that are covered by Medicaid but not by Medicare, CMS will be publishing “Medicare-like” rates for calendar years 2013 and 2014. These “Medicare-like” rates should be used for these codes.

Site of Service and Geographic Adjustments

This final rule removes the proposed requirement that states make site of service and geographic adjustments in paying at the applicable 2013 and 2014 Medicare rates. In the interests of administrative simplification, states need not make site of service adjustments but may reimburse all codes at the Medicare office rate, as opposed to the facility rate. With respect to geographic adjustments, states must either make all appropriate geographic adjustments made by Medicare, or may develop a rate based on the mean over all counties for each of the E&M codes specified in this rule.

The final rule no longer requires that states make all Medicare site of service and locality adjustments, although they may do so if they wish.

Non-Claims Expenses

Increases in non-claims expenses due to the enhanced payments will not be matched at 100% FFP. Following are some examples of these types of expenses:

- Administration expense
- Margin
- Underwriting gain that is a component in covering the cost of capital at risk
- Premium taxes or quality assessments/fees imposed by states
- Investment income due to lag between funding and claims

Figure 1 is an illustrative example of the high level components of the calculation that states should consider as they develop their methodology.

Figure 1:

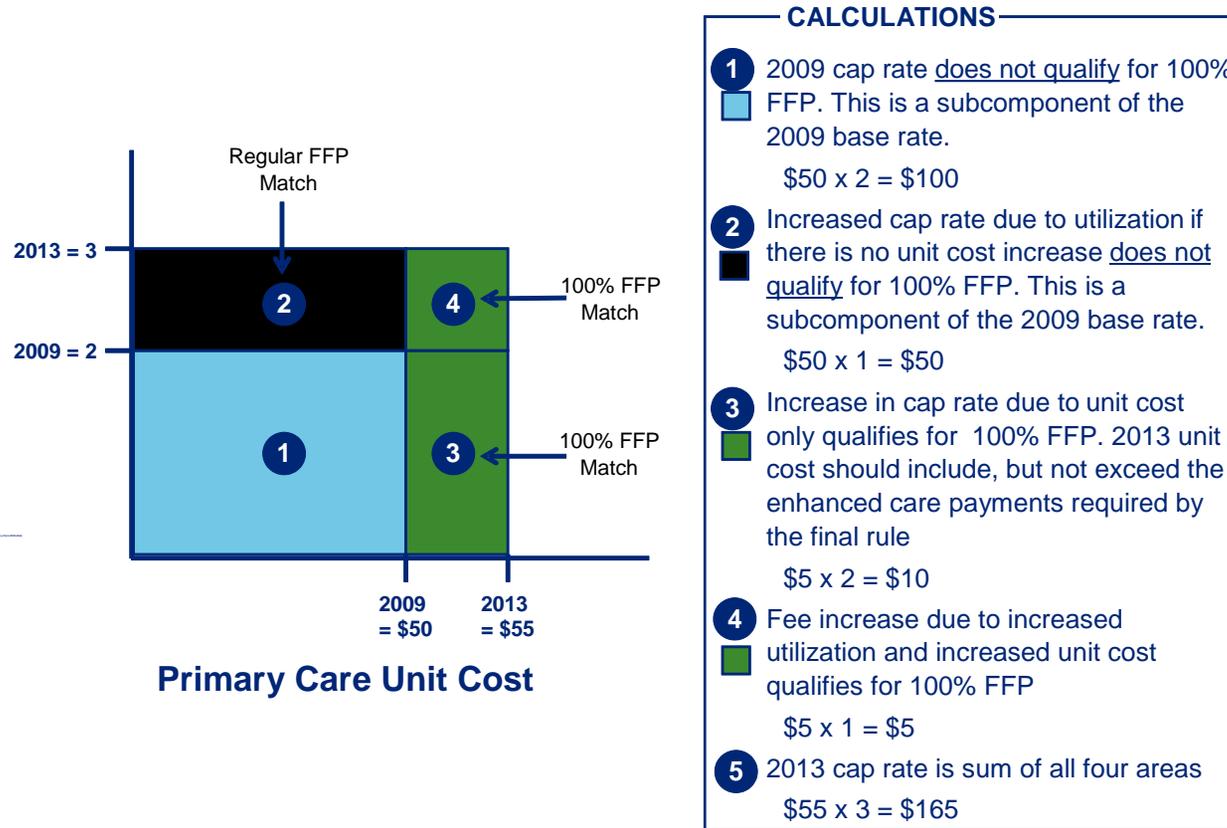


Figure 1 is an illustrative example of a 2013 calculation. Breaking down the subcomponents of the 2013 rate to reflect varying levels of FMAP is consistent with the intent of the statute and regulation, and any methodology which identifies these subcomponents would be acceptable to CMS. The methodology for a 2014 calculation would follow the same process.

In Figure 1, Segment 1 represents the primary care portion of the 2009 capitation rate based on the primary care provider definition and specific codes identified in the final rule. This portion of the 2013 capitation rate qualifies for the regular FFP match, but does not

		<p>qualify for 100% FFP. Note that in general this amount will be determined based on the rate setting methodology used to develop capitation rates in effect on July 1, 2009 as opposed to actual payments made by MCPs to providers in 2009.</p> <p>Segment 2 of Figure 1 represents the increase in the primary care portion of the 2013 capitation rate due to utilization if there is no increase in the unit cost. This segment is considered to be a component of the 2009 base rate and qualifies for the regular FFP match (i.e., it does not qualify for 100% FFP).</p> <p>Segment 3 of Figure 1 represents the increase in the primary care portion of the capitation rate due to the unit cost increase only (to include, but not to exceed, the enhanced primary care payments required by this rule). As stated in the final rule, this segment would qualify for 100% FFP. Similarly, Segment 4, which represents the increase in the capitation rate due to increased utilization and increased unit cost, also qualifies for 100% FFP.</p> <p>Therefore, in the Figure 1, the total primary care portion of the 2013 capitation rate is the total of all four segments. Of the total capitation rate, segments 1 and 2 would qualify for regular FFP match and Segments 3 and 4 would qualify for 100% FFP.</p> <p>The following Sections outline in more detail the considerations and methodologies for calculating the 2009 base rate, the 2013 capitation rate, and the differential that qualifies for 100% FFP.</p> <p>In addition to the considerations and methodologies described below, the guidelines provided in the CMS Medicaid Rate Setting Checklist should be kept in mind as well.</p>
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Section 4 – Calculating the 2009 Base Rate

4.0		<p>States Choosing Any Risk Sharing Model</p> <p>The 2009 base rate is developed based on the capitation rates that were in effect on 7/1/2009. The base rate for managed care is based on the payment between the state and the MCPs rather than the specific fee schedule between the MCPs and provider.</p> <p>The following steps should generally be used to calculate the 2009 base rate for the 2013/2014 FFP calculations:</p> <ol style="list-style-type: none"> 1. Determine the portion of the 7/1/09 and 2013/2014 capitation rates represented by primary care providers and HCPCS codes eligible for enhanced payment. For states with multiple rate cells, a weighted average capitation rate can be used 2. Determine the utilization and unit cost underlying the portion of the 7/1/09 and 2013/2014 capitation rates developed in step 1. The utilization and unit cost should be determined for each HCPCS code eligible for enhanced payment and should be consistent with the rate setting methodology used to develop the 7/1/2009 and 2013/2014 capitation rates. If the data necessary to calculate the utilization and unit costs for each HCPCS code is not available, other normative data sources may be used to reasonably estimate the portion of the primary care component of the capitation rate that aligns with the HCPCS codes. 3. Apply the code by code unit cost underlying the 7/1/09 capitation rate to the utilization underlying the 2013/2014 capitation rates. These are the 2009 base rates for the 2013 and 2014 100% FFP calculations, which are represented by the sum of Segments 1 and 2 of Figure 1 above.
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4.1		<p>Data Sources</p> <p>For the 2009 base rate calculation, the data should be the same data originally used to develop the capitation rates effective on 7/1/2009, if still available. If adjustments were made to the original data, then the same adjustments should be made when calculating the 2009 base rate. If the original data is not still available, other data may need to be used with appropriate adjustments, or the components of the capitation rates in effect at 7/1/2009 will need to be estimated using other actuarially sound techniques.</p> <p>The actuary should consider Actuarial Standard of Practice (ASOP) #23: “Data Quality” in the development of the calculations.</p> <p>Base utilization and cost data should be derived from the Medicaid population, or if not, adjusted to be consistent with the Medicaid population. Data should also be consistent with the Medicaid services and population covered under the state plan and should be free from material omissions.</p> <p>States without recent FFS history or validated encounter data will need to develop other data sources for this purpose. States and actuaries should consider which source(s) of data to use for this purpose based on which sources are determined to have the highest degree of reliability.</p> <p>Examples of potentially acceptable data sources include:</p> <ul style="list-style-type: none"> • Medicaid managed care encounter claims data • Medicaid FFS claims data • Medicaid managed care aggregated high level data • Medicaid MCP financial reports • Discussion with MCPs to obtain other helpful information • Non-Medicaid data with appropriate adjustments • Other data sources <p>Combination of the data sources above</p>

4.2		<p>Adjustments</p> <p>If adjustments were made to the original base data used to develop the 2009 capitation rates, then the same adjustments should be made when calculating the 2009 base rate.</p> <p><u>Utilization and Unit Cost Component Adjustments</u> It is assumed that base data used in the 2009 rate setting process were from a period prior to 2009 and utilization and unit cost adjustments were made to develop the rates in effect on 7/1/2009. Similar adjustments should be made when estimating the primary care utilization and unit cost inherent in the capitation rates in effect on 7/1/2009. These adjustments should be separated into the components applicable to utilization and unit cost in order to accurately estimate the components of the 7/1/2009 capitation rate as described in Section 4.0 above. Note that this calculation should be performed based on the actual capitation rates in effect on 7/1/2009 regardless of where they fit within the rate effective period. For example, if the rate effective period is 7/1/2009 through 6/30/2010 with a 12/31/2009 midpoint, six months of trend should not be backed out to get to the 7/1/2009 base rate. The actual capitation rates in effect on 7/1/2009 should be used.</p> <p><u>Adjustments not Allowed</u> <i>Increased payment would not be available for services provided by a physician delivering services under any other benefit under section 1905(a) of the Act such as, but not limited to, the Federally Qualified Health Center (FQHC) or Rural Health Clinics (RHC) benefits because, in those instances, payment is made on a facility basis and is not specific to the physician's services.</i></p> <p><i>This final rule defines the 2009 Medicaid base payment as excluding incentive, bonus and performance-based supplemental payments. Other volume-based payments, particularly those associated with academic medical centers, must be included in determining the 2009 base rate. This policy applies to fee for service and managed care payment.</i></p> <p>The following adjustments are specifically prohibited by CMS in the final rule from the 2009 base rate for the purposes of the calculation of the differential that qualifies for 100% FFP:</p> <ul style="list-style-type: none"> • FQHC/RHC payments - Not subject to 100% match rule • Incentive arrangements - The final rule defines the 2009 base Medicaid State plan rate as excluding performance-based supplemental payments such as bonus, pay for performance, and incentive payments since they are not fee schedule payments. Other volume-based payments, particularly those associated with academic medical centers, must be included.
4.3	42 CFR Part 438, 441, and 447 I.B.4.a	<p><u>Dual Eligibles</u> <i>In CYs 2013 and 2014, the Medicaid rate for primary care services by the specified physicians will equal the Medicare rate. As a result, these physicians should receive payment up to the full Medicare rate for primary care services and 100% FFP will be available for the full amount of the Medicare cost sharing amount that exceeds the amount that would have been payable under the state plan in effect on July 1, 2009.</i></p> <p><i>This rule does not in any way negate the need for states to comply with all Medicaid requirements applicable to payment for services provided to Medicaid beneficiaries who are also dually eligible for Medicare. In managed care environments, states will be granted flexibility in determining the portion of the capitated payment that is related to such beneficiaries. However, the methodology must be approved by CMS.</i></p>

		<p>For managed care programs, this provision of the rule only applies to states that cover dual eligibles under capitated managed care capitation rates that include primary care cost sharing or other eligible primary care payments not covered by Medicare. Primary care cost sharing is only eligible for 100% FFP in 2013 and 2014 if it exceeds the amount that would have been payable under the state plan in effect on July 1, 2009. We believe these amounts could be nominal and a state could choose to forgo estimating these amounts. However, should a state choose to estimate the amount eligible for 100% FFP, the state must provide their methodology to identify how they estimated the amount eligible for 100% FFP.</p>
<p>Section 5 – Calculating the 2013/2014 Capitation Rate</p>		
<p>5.0</p>	<p>42 CFR Part 438, 441, and 447 I.B.1.a</p>	<p>States Choosing Risk Model 1 or Model 2</p> <p>The calculation of the 2013/2014 capitation rates is a requirement of the rate setting package. When certifying the rates, the actuary should consider the requirements of 42 CFR 438.6(c) for capitated Medicaid managed care programs. The guidelines provided in the CMS Medicaid Rate Setting Checklist should be kept in mind as well. The 2013/2014 capitation rates should also be developed in accordance with this final rule, as follows:</p> <p><i>Section 1902(a)(13) of the Act requires payment by state Medicaid agencies of at least the Medicare rates in effect in calendar years 6 (CYs) 2013 and 2014 or, if higher, the rate that will be applicable using the CY 2009 Medicare conversion factor (CF), for primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine.</i></p> <p>CMS recently published the final rule establishing Medicare physician rates for CY 2013. Under current law, the 2013 Medicare conversion factor is expected to be less than the 2009 conversion factor. Therefore, it appears that states will be expected to pay rates in 2013 for the codes identified in this final rule that are developed using the 2009 conversion factor and 2013 RVUs. We will refer to this calculation as the 2013 Medicare enhanced rates throughout the rest of this document. The rule will need to be revisited in 2014 to determine the Medicare rate.</p> <p>In addition to using the 2013/2014 Medicare enhanced rates for the 2013/2014 capitation rates, the states should also consider the following provisions of the final rule when calculating the rates:</p> <ul style="list-style-type: none"> • Qualified providers • Eligible codes • Site of service adjustments • Geographic adjustments <p>The state should be able to split the 2013/2014 capitation rates into utilization and unit cost components as the utilization for the specified services will be needed for calculating the 2009 base rate as described in Section 4.0 above. The enhanced unit cost for these services within the capitation rate would be based on the Medicare fee schedule as specified in the final rule.</p> <p><u>Adjustments not Allowed</u></p> <p><i>Increased payment would not be available for services provided by a physician delivering services under any other benefit under section 1905(a) of the Act such as, but not limited to, the Federally Qualified Health Center (FQHC) or Rural Health Clinics (RHC) benefits because, in those instances, payment is made on a facility basis and is not specific to the physician’s services.</i></p> <p><i>This final rule defines the 2009 Medicaid base payment as excluding incentive, bonus and performance-based supplemental payments.</i></p>

		<p><i>Other volume-based payments, particularly those associated with academic medical centers, must be included in determining the 2009 base rate. This policy applies to fee for service and managed care payment.</i></p> <p>The following adjustments are specifically prohibited by CMS in the final rule from the 2013/2014 capitation rate for the purposes of the calculation of the differential that qualifies for 100% FFP:</p> <ul style="list-style-type: none"> • FQHC/RHC payments - Not subject to 100% match rule • Incentive arrangements - The final rule defines the 2009 base Medicaid State plan rate as excluding performance-based supplemental payments such as bonus, pay for performance, and incentive payments since they are not fee schedule payments. Other volume-based payments, particularly those associated with academic medical centers, must be included.
5.1		<p>States Choosing Risk Sharing Model 3</p> <p>The 2013 capitation rate will set as if this provision were not in place (i.e. based on a Medicaid fee schedule which does not reflect the Medicare rate). At the end of each quarter (or an agreed upon period) the MCPs would summarize actual encounter data or another reasonable data source to calculate the total payment the primary care providers would need to be paid in order to reach the 2013 Medicare enhanced payment rates.</p> <p>The state would review this report and, if found reasonable, the state would pay the MCPs the additional payment amount. The MCPs would then distribute those payments to eligible primary care providers, and the State would claim the enhanced Federal match for those payments.</p> <p>To summarize, under this model, the state does not set a capitation rate that includes the enhanced payment rates for eligible primary care services. Therefore, CMS would only expect to review and approve the methodologies required under 42 C.F.R. 438.804(a)(1) and the MCP contracts.</p>
<p>Section 6 – Calculating the Differential that Qualifies for 100% FFP</p>		
6.0		<p>States Choosing Risk Sharing Model 1</p> <p>After the states have calculated the appropriate 2013/2014 capitation rates using the 2013/2014 Medicare enhanced rates and the 2009 base rate, the state can calculate the 100% FFP amount. Below is an example based on Figure 1 outlining the steps the states could follow when calculating the 100% FFP amount. Although this example is for a 2013 calculation, a similar process would be followed for a 2014 calculation.</p> <ol style="list-style-type: none"> 1. Apply the projected 2013 utilization to the 2013 Medicare enhanced unit cost to calculate the 2013 primary care capitation rate. In the example in Figure 1 above this portion would represent the 2013 Medicare enhanced unit cost rate of \$55 multiplied by the 2013 utilization of 3 to calculate the 2013 primary care capitation rate of \$165 (Segments 1, 2, 3 and 4 of Figure 1) 2. Apply the 2013 projected utilization to the calculated 2009 base rate unit cost calculated in Section 4. In the example in Figure 1 above this portion would represent the 2009 base rate fee of \$50 multiplied by the 2013 utilization of 3 to calculate \$150 (Segment 1 plus Segment 2 of Figure 1). Note that in practice this would be done on a code by code basis for all eligible primary care codes. 3. Determine the 100% FFP amount by calculating the difference between Step 1 and Step 2. In the example in Figure 1 above the amount eligible for 100% FFP would be equal to \$165 minus \$150, or \$15 (Segment 3 and Segment 4 of Figure 1) <p>There is no retrospective reconciliation in this model.</p>

6.1		<p>States Choosing Risk Sharing Model 2</p> <p>The states would calculate the prospective 100% FFP amount following the same approach as shown in Section 6.0. However, the states will perform an additional calculation at the agreed upon time of reconciliation. This reconciliation would be performed on a basis agreed upon between the state and the MCPs and approved by CMS. At the time of reconciliation, if there was an overpayment or an underpayment the state will reconcile with the MCPs and CMS.</p>
6.2		<p>States Choosing Risk Sharing Model 3</p> <p>The states would calculate the prospective 100% FFP amount following an approach similar to that shown in Section 6.0. However, this calculation will occur after the states have allowed for a sufficient amount of time for claim run-out. At that point the actual utilization will be used rather than the projected utilization noted in Section 6.0.</p> <p>In model 3 the unit cost underlying the eligible primary component of the 7/1/09 capitation rate will need to be developed as described in Section 4 above. The actual utilization will be multiplied by these unit costs at the HCPCS code level in order to develop the 2009 base. This amount will be subtracted from the final 2013/2014 payments for these services in order to develop the amount eligible for 100% FFP.</p>
<p>Section 7 – Rate Setting Documentation</p>		
7.0	<p>42 CFR Part 438, 441, and 447 II.A.5.</p>	<p>States are required to submit the methodology used to identify the increment of the capitation payment attributable to increased provider rates to CMS for approval by the end of the first quarter of calendar year 2013. The same methodology information will need to be provided by the end of the first quarter of calendar year 2014 if the methodology is changed for 2014. Absent approval of the methodology from CMS, states will not be able to claim the enhanced Federal match for capitation payments to managed care plans.</p> <p>All 2013 and 2014 rate setting packages must acknowledge the risk model used by the state to implement this provision. A state using a non-risk model (i.e. model 3) should provide documentation consistent with the requirements of 42 C.F.R. 438.6(c) and CMS does not expect to see any further reference to this provision in the rate-setting documentation.</p> <p>States using any risk-based/prospective payment model should address the following concepts and calculations in their rate-setting documentation (in addition to those required by 42 C.F.R. 438.6(c):</p> <ol style="list-style-type: none"> 1. Calculation of the 2013/2014 capitation rates 2. Calculation of the 2009 base rate (unit cost inherent within the capitation rates in effect on 7/1/2009 for the specified services) 3. Calculation of the differential between the 2013/2014 capitation rate and the 2009 base rate to determine the amount eligible for 100% FFP <p>The rate package documentation should describe the relevant data, source(s) of data, material assumptions, methods, and process by which the calculations were developed with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work as presented in the actuarial report.</p> <p>The documentation should address the following issues, to the extent they are relevant and material:</p> <ul style="list-style-type: none"> • Choice of experience period and data <ul style="list-style-type: none"> ○ Will usually be selected to be the most recent for the 2013 capitation rate, with sufficient time for reasonable run-out. If a

		<p>different period is used it would typically be disclosed and explained.</p> <ul style="list-style-type: none"> ○ For the 2009 base rate, it should be the same data used to develop the capitation rates effective on 7/1/2009, if still available. If that data is not still available, other data may need to be used with appropriate adjustments, or the unit cost inherent within the capitation rates in effect at 7/1/2009 will need to be estimated. ● Adjustments and use of external data <ul style="list-style-type: none"> ○ Source and relevance of any adjustments made or external data used in “completing” or enhancing the data ○ For the 2009 base rate, the adjustments to unit cost should be the same as those applied when originally developing the capitation rates in effect on 7/1/2009. <p>The documentation should address the data used, adjustments to experience data, methodology for the calculation of the differential that qualifies for the 100% FFP, etc. For 2014 the same concepts and documentation requirements apply.</p>
Section 8 – Contract Requirements		
8.0	42 CFR Part 438, 441, and 447 II.A.5	<p><i>We will review and approve the methodologies and refer to these methodologies to approve MCO, PIHP and PAHP contract amendments and rates necessary to implement this rule. This rule does not require a specific method for the MCOs, PIHPs or PAHPs to make the enhanced payment for primary care services to eligible providers, but the approach taken must ensure that the eligible primary care provider receives the full benefit of the enhanced payment. In deference to the wide variation in states’ current oversight and reporting mechanisms for health plans, we will permit states to specify the documentation needed from health plans to substantiate that the enhanced primary care rate was delivered to eligible primary care providers. The health plans must make such documentation available to the state for verification of payments made as well as make such documentation available for audit or reconciliation processes.</i></p> <p>The state contracts with the MCPs must be amended to reflect the requirements of this provision and provided to CMS for review and approval. CMS will review the relevant contract language to ensure, at a minimum, that:</p> <ol style="list-style-type: none"> 1. The MCPs are required to pass on the full benefit of the payment increase to eligible providers; 2. The MCPs are required to adhere to the definitions and requirements for eligible providers and services as specified in the statute and regulation; and 3. The MCPs are required to submit sufficient documentation, as specified by the state, to the state, to validate that that enhanced payments were made to eligible providers. <p>Further, if a state elects a non-risk payment model to the MCPs that should be clearly identified in the contract as a separate payment arrangement.</p>
Section 9 – References		
9.0		<p>CMS released the final rule, “Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration under the Vaccines for Children Program”, on November 6, 2012. Below is a link to the final rule:</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf</p>

9.1		<p>A practice note was prepared by a work group organized by the Health Practice Council of the American Academy of Actuaries. The purpose of the practice note is to provide nonbinding guidance to the actuary when certifying rates or rate ranges for capitated Medicaid managed care programs. Below is a link to the practice note:</p> <p>http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf</p>
9.2		<p>Regulations governing the development of actuarially sound rates are outlined in 42 CFR 438.6(c). Below is a link to those regulations:</p> <p>http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=ffbb43ae09887f0272624c881960d38d&rgn=div5&view=text&node=42:4.0.1.1.8&idno=42</p>
9.3		<p>Questions and Answers issued by CMS related to this rule are available at:</p> <p>http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/CMCS-Ask-Questions.html</p>