

PCP rate FAQs on our website. MCOs might like to see, or be reminded of.

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.

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.

The NPRM provided that states were required to pay the lesser of the provider's charges or the applicable Medicare rate. The final rule no longer specifies this. Can a state continue to pay at the lower of the two amounts?

Under Medicare and Medicaid principles, payment is to be made at the lower of provider charges or the rate, which in this case is the applicable Medicare rate. This language was inadvertently omitted from the final rule. CMS is processing a technical correction to the regulatory text at 42 CFR 447.405 to restore this language.