Increased Medicaid Managed Care Payment for Primary Care

QUESTION & ANSWER DOCUMENT

The Affordable Care Act (ACA) provides a rate increase for certain primary care Medicaid services in 2013 and 2014. HHSC will issue quarterly supplemental payments to providers to cover the difference between the regular Medicaid rate for the service and the temporary increase. Capitation rates will not be adjusted for the enhanced primary care payments. Rather, actual encounter data will be queried on a quarterly basis to calculate the total payments that eligible providers were paid for eligible services in order to reach the mandated enhanced payment rates.

1. **Which Medicaid providers qualify for payment?**
   To be eligible to receive supplemental payments, Providers must complete and submit an attestation form to TMHP. The form is available on the TMHP website. http://www.tmhp.com/Provider_Forms/Medicaid/ACA%20Primary%20Care%20Attestation.pdf. Only physicians who meet the specialty and board certification or Medicaid billing volume requirements described on the attestation form are eligible for supplemental payments.

2. **Will MCOs need to collect attestation forms or verify that providers are qualified?**
   No. TMHP will be collecting the attestation forms and verifying provider qualifications. MCOs will only be responsible for passing through payments to the providers that are on the file that HHSC provides to each MCO.

3. **What is the cutoff date when providers must attest by to receive retro-active payments back to 1/1/2013?**
   Physicians who complete the form before April 1, 2014 will qualify to get the rate increase payments for services provided since January 1, 2013. Those who complete the form after April 1st will get the rate increase payments only for services provided from the date they completed the form.
   Note: providers that complete a form prior to April, but receive notification that the form is incorrect or incomplete will be held-harmless to the original date the application was received. However, payments will only be issued for providers who meet the federal requirements.

4. **How often will the state supply a list of eligible providers?**
   The state will provide the MCOs with a list of eligible providers at the least on a quarterly basis.

5. **What will be frequency for updating the eligible provider listing?**
   TMHP has generated a list of all attestation forms received up to 10/16/13 which can be found at http://www.tmhp.com/TMHP_File_Library/ACA/PCP%20Attestation%20List.pdf. An additional list will be generated and posted on www.tmhp.com once all the attestation forms have been received, validated and entered into the system. This list will be posted during the month of February, 2014. All completed attestations received prior to 4/1/14 will be retroactive to 1/1/13.

6. **Do providers practicing in FQHCS and RHCs qualify for higher payment?**
   The rate increase does not apply to services provided in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

7. **What will qualified providers be paid?**
   Qualified providers will be paid the amount equal to the difference between the paid amount reflected on the submitted encounter, and the minimum payment required under Federal law.

8. **When will the state begin making the supplemental payment for providers in Medicaid managed care?**
   The state will begin sending payments and files with the list of providers to MCOs before the end of January 2014. MCOs have up to 60 days to make those payments and provide HHSC with of confirmation of payment per Chapter 13 of the UMCM. However, HHSC strongly encourages MCOs to pass-thru provider payments as soon as possible.

9. **How will the state determine the supplemental payment owed to the providers based on MCO encounter reporting?**
   The supplemental payment calculation will be based on the difference between the "paid amount" reported on the submitted encounter and the Medicare rate for the service in question.

10. **Do physicians practicing in FQHCS and RHCs qualify for higher payment?**
    The rate increase does not apply to services provided in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

11. **Can mid-level/non physician practitioners such as nurse practitioners receive the higher payment?**
    Per federal law, only a physician can self-attest to meeting the qualifications for the rate increase. Mid-level/non physician practitioners can receive the higher payment only if they bill under the supervision of a qualified attested physician's NPI. Only encounters submitted with an attested provider's NPI in the Rendering/Performing Provider field are eligible for supplemental payments.

12. **Will the state be calculating the rates for midlevel providers using 100% of Medicare or a lower percentage?**
    Mid-level/non physician practitioners can receive the higher payment only if they bill under the supervision of a qualified attested physician's NPI.

13. **Why is my payment less than expected?**
    Providers can call the TMHP contact center at 1-800-925-9126 for questions related to the ACA PCP rate increase payments.

14. **Why are my list of claims less than what I submitted?**
    Providers can call the TMHP contact center at 1-800-925-9126 for questions related to the ACA PCP rate increase payments.

15. **Does the payment go from Medicaid allowable to Medicare allowable or my contract rate to Medicare allowable?**
    The supplemental payment calculation will be based on the difference between the "paid amount" reported on the submitted encounter and the Medicare rate for the service in question.

16. **Who do I call for questions?**
    Providers can call the TMHP contact center at 1-800-925-9126 for questions related to the ACA PCP rate increase.

17. **What if a provider feels they were under paid?**
    Providers can call the TMHP contact center at 1-800-925-9126 for questions related to the ACA PCP rate increase.

18. **What if the provider did not attest all TPI numbers. Are they still eligible for the retro payment back to January 1, 2013?**
    Providers must complete the self-attestation process and include all the appropriate information on the form including all associated TPI's and group TPI's in order to be eligible for the ACA PCP rate increase. TMHP will be reaching out to providers whose form is incorrect or incomplete. If a provider has additional questions about the completion of the form they can call the TMHP contact center at 1-800-925-9126.

19. **What if group NPI was used, who gets the money?**
    Only individual providers are eligible to submit attestation forms. MCOs should ensure that Group practice providers are aware of requirements in Chapter 13 of the Uniform Managed Care Manual (UMCM) and other requirements that govern distribution of the supplemental payment to the attested provider.

20. **When will the rest of the retroactive provider supplemental payments be paid?**
    The state will begin sending payments to MCOs by the end of January 2014. MCOs have up to 60 days to make payments to providers and confirm payments have been pass-thru to HHSC. HHSC strongly encourages MCOs to pass-thru payments as soon as possible. The first set of managed care payments will be for the first quarter of 2013. Beginning in April of 2014, TMHP will begin making payments to providers in FFS and begin sending payments to MCOs. Those payments will be for all remaining retro-active payments for January 2013 and the first quarter of 2014.

21. **Where will the file be sent to and who will be notified?**
    The MCO Payment file will be posted to TxMed Central, in each MCO's XXXLIB folder. A notification will be sent to all MCOs when files are available.

22. **Will the state be supplying a reporting template to the MCO's, or should the MCO's create one?**
    HHSC has provided MCOs with Payment and Payment Response File specifications.

23. **Will the MCO's receive a test file prior to submission of the first eligibility report?**
    Yes. Test files were provided on 1/19/2014.

24. **Will the file be a complete refresh or updates only?**
    The MCO Payment file will contain updates only.

25. **Who should we notify if the file contains an unknown provider?**
    All MCO supplemental payments are calculated and issued based on submitted encounter data, so all providers are already known to the MCO. The MCO Payment file will contain Claim/Encounter ICN reference information to assist the MCO with identifying the original claim in their system.

26. **On what FSR line should we report?**
    The MCO must report all funding received for and supplemental payments made pursuant to this chapter as separate line items on its Financial Statistical Reports (FSRs).

27. **How will eligible providers be identified in the file?**
    HHSC will provide an electronic MCO Payment file to accompany each payment. This file will include the Billing and Rendering NPI that the MCO submitted for each underlying encounter event and the associated supplemental payment amount. The MCO Payment file will contain the ICN number that the MCO submitted for each encounter which to allow the MCO to identify the associated claim in their system.

28. **Ensuring payments are disbursed to individual physicians. What process does the state expect MCO's to follow to audit this ask?**
    MCOs should issue the supplemental payment consistent with the original claim payment. MCOs should also ensure that Group practice providers are aware of requirements in Chapter 13 of the Uniform Managed Care Manual (UMCM) and other requirements that govern distribution of the supplemental payment to the attested provider.

29. **How will provider appeals be handled?**
    Providers will need to call the TMHP contact center at 1-800-925-9126 for all inquiries related to the ACA PCP rate increase.

30. **Will there be an update to the PPACA fee schedule? The latest 2014 RVUs were released and are lower on almost every E&M code (2013 RVUs).**
    Yes, 2014 rates will be calculated consistent with requirements in federal law.

31. **Will the MCO have to do any additional CAP calculations as the state is handling all PPACA calculations?**
    MCOs are not required to do any calculations. HHSC/TMHP will calculate all payments. MCOs are only responsible for passing payment to the provider, and providing HHSC with the Payment Response file, as required in UMCM Chapter 13.

32. **Will HHSC be issuing any clarification on how to handle non-participating rendering providers?**
    Provider payments should be passed through to all providers as indicated on the MCO payment file, regardless of the provider's contract status with the MCO. As all payments are calculated based upon submitted encounter data, MCOs have previously submitted payments to any provider included on the MCO Payment file.

33. **How will capitated managed care PCPs payments be calculated?**

The state will utilize the FFS Medicaid rate, as the "Paid Amount" in the payment calculation. For qualifying encounter events with the "Capitated Provider" Financial Arrangement Code (where the paid amount is $0,) Providers will receive a supplemental payment for the difference between the FFS Medicaid rate and the corresponding Medicare Rate for the service in question.

34. **Can tax id and payee name be added to the file that will be sent to the MCO's? At a minimum, tax id is critical to ensure the MCO's cut checks to the appropriate groups, as some providers practice with multiple groups?**

HHSC will provide an electronic MCO Payment file to accompany each payment. This file will include the Billing and Rendering NPI that the MCO submitted for each underlying encounter event and the associated supplemental payment amount. The MCO Payment file will contain the ICN number that the MCO submitted for each encounter which will allow the MCO to identify the associated claim in their system. MCOs can utilize Tax ID or other values needed to for payment by referencing their original claim payment.

35. **Why did the payments not include the full list of providers identified on TMHPs website?**

Interim payments are limited to providers for which TMHP has confirmed there are no inaccuracies on the original attestation form and who qualify for the payment. Providers who submitted attestation forms for which there are outstanding questions will be contacted by TMHP and held-harmless to the original date for submission. Payments to these providers will be captured in the retro-active payment process to begin in April. Additionally, any claims not captured in the interim payment process, but eligible for the increase, will be captured during the retro-active payment process in April which will include a reconciliation of payments issued and payments outstanding.