

CHAPTER 8

# An Update on the Medicaid Primary Care Payment Increase

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## Key Points

- The Medicaid primary care payment increase, which temporarily raised Medicaid fees for primary care services to Medicare levels, expired on December 31, 2014. MACPAC conducted semistructured interviews with Medicaid officials, plan administrators, and provider organizations in eight states during the summer of 2014 to shed light on whether they thought the temporary increase affected access to primary care and to help us understand states' implementation experiences.
- In those interviews, states, Medicaid managed care plans, and provider organizations reported the following:
  - Early operational issues delayed initial payments to providers, but were largely resolved by the summer of 2014.
  - The payment increase took effect in fee for service and Medicaid managed care at different times in four of the seven states. Some providers found these separate implementation time frames confusing.
  - The payment increase had little to no effect on Medicaid provider participation rates according to state and Medicaid managed care officials.
  - There was no change in primary care service use while the payment increase was in effect according to interviewees in six of the eight states.
- Whether the primary care payment increase affected access to primary care remains unclear.
  - Studies in other states found that providers increased the number of Medicaid patients they were willing to see, or that Medicaid appointment availability increased concurrent with the payment increase.
  - However, the eight states interviewed reported to MACPAC that the payment increase had little effect on recruiting Medicaid primary care providers, as few providers who participated in the increase were new to Medicaid. Moreover, some providers may not have been aware of the payment increase.
- Now that the primary care payment increase has expired, states are taking different approaches to their Medicaid payment policies:
  - At least twenty-four states reverted to their previous primary care physician payment rates.
  - Fourteen states will continue to pay primary care physicians at higher levels in 2015 than their pre-2013 levels although not necessarily as high as Medicare. One state, Alaska, paid higher Medicaid rates to primary care providers than Medicare paid prior to the payment increase, and will continue to do so.

## CHAPTER 8: An Update on the Medicaid Primary Care Payment Increase

The Medicaid primary care payment increase, a provision in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that temporarily raised certain Medicaid physician fees, expired on December 31, 2014. The provision required that all state Medicaid programs increase payment for certain primary care services to Medicare payment levels during calendar years 2013 and 2014. The payment increase was intended to address the need to maintain provider networks for those currently enrolled in Medicaid in light of the ACA-mandated expansion of Medicaid eligibility (later made optional by the U.S. Supreme Court), which was expected to cover millions of additional enrollees. This increase in payment rates was fully federally funded; to date, the federal government has spent \$7.1 billion on increased payments for services, and this total is expected to grow as states continue processing eligible claims (MACPAC 2015).<sup>1</sup>

Although the provision seemed like a straightforward rate increase, it proved complicated to implement. States had to identify eligible providers and maintain separate fee schedules to pay eligible providers the enhanced rate while paying ineligible providers a lower rate, and they had to work with their Medicaid managed care organizations (MCOs) to do the same for their providers. State, plan, and provider-organization representatives expressed concerns from the outset that these operational issues might overwhelm any effect of the payment increase on access to primary care (MACPAC 2013).

The results of emerging research are inconclusive on whether the payment increase had an effect on access to primary care in Medicaid. We

interviewed state Medicaid agencies, Medicaid MCOs, and provider organizations between June and September 2014. We learned that although early operational issues had largely been resolved, uneven implementation led to payment delays. These delays, combined with the short time frame in which the provision was in effect, made it difficult to measure its effects before it expired. Most states have not evaluated the effect of the payment increase on provider participation, and data required for federal evaluations are not yet available. Even though evidence of the effect of the payment increase is mixed, some states are continuing to pay Medicaid primary care providers at higher rates even without the enhanced federal matching funds.

This chapter builds on earlier Commission work that examined states' planning efforts and early issues they encountered while implementing the Medicaid primary care payment increase. We begin with a review of the statutory and regulatory requirements for states and the decisions states made as they implemented the payment increase. We then present findings from recent MACPAC interviews with state Medicaid agencies, managed care plans, and provider organizations that we conducted prior to the provision's expiration. We also present early findings from research conducted by other organizations. We conclude by briefly discussing possible implications of the temporary primary care payment increase on future policy development.

### Statutory and Regulatory Requirements

The Centers for Medicare & Medicaid Services (CMS) published a final rule for the implementation of the primary care payment increase provision in November 2012, less than two months before the provision was to take effect. The rule specified the types of services and providers to which the temporary payment increase would apply. CMS responded to implementation questions

by providing additional subregulatory guidance. Several statutory and regulatory requirements are described below.<sup>2</sup>

The payment increase was limited to evaluation and management services (Current Procedural Terminology codes 99201–99499) and vaccine-administration services and counseling related to children’s vaccines (Current Procedural Terminology codes 90460, 90461, and 90471–90474).

Providers were eligible for the payment increase if they were practicing primary care and specializing in family medicine, general internal medicine, or pediatric medicine or in a subspecialty recognized by one of three physician-certifying boards.<sup>3</sup> Other health professionals could be eligible if they provided primary care services under the supervision of an eligible physician. Providers were also required to self-attest to their eligibility by providing evidence of board certification in one of the specialties or subspecialty designations or attest that they practiced primary care and had an eligible claims history.<sup>4</sup>

States were required to review a statistically valid sample of the physicians who received the higher payments in calendar years 2013 and 2014 to retrospectively verify their eligibility for the payment.

States also had to submit information to CMS about physician participation and beneficiary use of services. Specifically, states were required to submit provider participation information as of July 1, 2009, and for calendar year 2013 as well as service utilization information for corresponding time periods, at a time to be specified later by CMS (42 CFR 447.400(d)). However, as noted in MACPAC’s June 2013 *Report to the Congress on Medicaid and CHIP*, these data would not be available until after the provision expired at the end of 2014.

States were required to submit a state plan amendment with their proposed implementation procedures by March 31, 2013. Nearly all state plan amendments were approved by June 2013.

Implementation of the payment increase was more complicated in state managed care programs than in fee-for-service programs because Medicaid MCOs use a variety of methods to pay physicians, including subcapitation arrangements, bundled payments, or proprietary fee schedules not aligned with the Medicaid fee schedule. In order to implement the payment increase, states and their Medicaid MCOs had to develop a methodology to identify the services covered by the payment, calculate the amounts owed, and verify that the plans paid the enhanced primary care rate to eligible providers. States also had to develop a methodology to adjust capitation payments paid to MCOs to reflect the rate increase. These methodologies were then submitted as part of the standard CMS review of MCO contracts during 2013 and 2014.

As noted in MACPAC’s June 2013 report, states had difficulty complying with the regulations and associated requirements to file state plan amendments and amend MCO contracts. MACPAC conducted semistructured interviews with state Medicaid officials, Medicaid MCOs, and provider organizations in six states and the District of Columbia between mid-October 2012 and January 2013, when the provision was being implemented. In those interviews, states reported that the late publication of the final regulation gave them little time to be ready to make increased payments on January 1, 2013. States also reported difficulty identifying eligible providers and implementing the increase within their MCOs. In many states, the provision required complex system modifications to the Medicaid Management Information Systems used to process and adjudicate claims.

MACPAC’s June 2013 report also highlighted the importance of conducting a comprehensive evaluation of the effect of the primary care payment increase, ideally using national claims data and adjusting for other factors, such as enrollment changes due to Medicaid expansion. The report stressed that provider enrollment data and patient load data could provide insight into whether provider participation changed and

## BOX 8-1. State Implementation Decisions about the Primary Care Payment Increase

State Medicaid agencies have flexibility to establish their own payment methods and policies within broad federal parameters. In light of this flexibility, the regulations gave states some options for implementing the primary care payment increase. A review of the approved state plan amendments for the primary care payment increase showed variation in how states implemented the provision. Some examples are listed below:

- Thirty-four states planned to pay at the office-setting rate rather than make site-of-service adjustments.
- Fifteen states implemented a statewide average rate across all counties rather than implement all Medicare geographic adjustments.
- Thirty-four states planned to implement the payment increase on a per claim basis, while 16 states planned to make a lump-sum supplemental payment.
- Forty-two states indicated that some new services had been added to the fee schedule after July 1, 2009, although these were typically Current Procedural Terminology codes not in use prior to that date.
- Nearly all states excluded certain codes from the payment increase; the services excluded and the number of codes varied by state.

whether providers saw a larger share of Medicaid patients relative to their patients with other sources of coverage. The Commission noted that these data would not be available until well after the provision expired at the end of 2014.

## Update on Experiences with Implementation: MACPAC Interviews

MACPAC conducted semistructured follow-up interviews with officials in eight states (Alabama, Kentucky, Michigan, Missouri, New Mexico, Rhode Island, Virginia, and Washington).<sup>5</sup> Twenty-nine interviews were conducted between July and September 2014. Interviewees included state Medicaid officials and technical staff, operations

and policy staff from Medicaid MCOs, and provider organizations, including state medical societies, primary care associations, and pediatric associations. Respondents were asked to draw on their experiences and, to the extent possible, available data in answering interview questions. Interviewees were assured that their responses would not be attributed to them by name, or to their organization.

These interviews were intended to shed light on whether states thought that the temporary increase had an effect on access to primary care and to help us understand state experiences during implementation. The responses made clear that states experienced some operational challenges initially, and that increased payments to providers were delayed in most states. States reported that the payment increase had, at best, a modest effect on provider participation, although states

were cautious in attributing increases in provider participation solely to the payment increase.

**Operational challenges had largely been resolved.**

Every state we interviewed reported experiencing some operational challenges as they implemented the payment increase. For example, some states reported initial challenges in identifying eligible providers, either because they did not have specialty or board certification information on file or because they thought information from CMS on the parameters for determining physician eligibility lacked clarity.<sup>6</sup> States also reported experiencing additional administrative burden in establishing the self-attestation process. Nearly all states took the lead in collecting attestation forms and reporting physician eligibility to MCOs, and this created some challenges for states with MCOs that used different provider identification numbers although these issues were resolved quickly. States and MCOs reported that adjusting the state payments to the MCOs was another challenge. States and MCOs had to determine the share of the capitation payment that was attributable to eligible primary care services. Coming to a CMS-approved methodology took considerable time and effort.<sup>7</sup>

**Timeliness of payments.** Most states reported making the first increased payments (including retroactive payments) in May 2013 or later. States attributed the delayed payments to the late publication of the final rule and the operational challenges they faced in implementing the payment increase. Some respondents, including state officials and provider organizations, expressed concern that these delays may have initially cast doubt among providers over whether they would receive a payment increase. They also noted that payment delays shortened the window in which providers experienced the increase and cited this as a factor that may have limited any effect the increase had on provider behavior.

The payment increase was implemented at different times in fee for service and Medicaid managed care plans in four of the seven states

interviewed. Some providers found the separate implementation time frames confusing, according to a few states and provider organizations.

**Effect on provider participation.** States and Medicaid MCO officials interviewed reported that the payment increase had little to no effect on provider participation rates in Medicaid.<sup>8</sup> Of the eight states surveyed, two states reported no change in provider participation rates; three states said that provider enrollment increased from 2012 to 2013; and the other three states said that they thought that provider enrollment had increased, but that they did not monitor provider enrollment figures closely. Seven MCOs (in five states) reported no noticeable change in provider enrollment. Nearly all of the respondents in the states reporting actual or presumed increases in provider enrollment cautioned that the increases could not be solely attributed to the provision. Other factors may also have had an effect on provider participation, such as Medicaid expansion and other state efforts to improve access to primary care services for Medicaid enrollees.

Some of the states reported that their enrollees had adequate access to care prior to the payment increase. These states reported that Medicaid represented a large share of their state's health insurance coverage, and gave this as a reason for high provider participation. For example, one state pointed to state regulations that require providers participating in an insurance carrier's commercial market must also participate in that insurer's Medicaid market if the insurer offers a Medicaid plan.

Provider participation in the payment increase varied by state. Four states reported that between 23 and 92 percent of eligible providers completed attestations.<sup>9</sup> All states said that few physicians who completed self-attestations were new to Medicaid. One state estimated that fewer than 1 percent of those who completed self-attestations were new to Medicaid, and several other states provided similarly low estimates.

In addition to provider participation, Medicaid patient load can be considered an indicator of access.<sup>10</sup> All states and MCOs reported that they did not have data to determine whether providers increased their Medicaid patient loads, and providers reported that they had not increased their Medicaid patient loads.

#### **Amount of increase for primary care services.**

While the amount of the payment increase for each service could be easily determined, quantifying the amount of additional payments made to individual providers as a result of this provision was challenging for most interviewees.<sup>11</sup> For example, states either did not routinely track payments made at the individual provider level or lacked MCO data to provide a complete provider-level estimate. Provider associations in two states had attempted to estimate how much providers had received on average, but ultimately determined that data were unavailable.

**Effect on primary care service use.** Two states reported an increase in use of primary care services. These states reported increases of between 1 and 7 percent in the use of primary care services in both fee for service and managed care programs.<sup>12</sup> Participants in the remaining six states reported that there was no change in primary care service use during the time the provision was in effect. As with provider participation data, states cautioned that changes in primary care service use could not be solely attributed to the provision. Provider organizations reported that they did not have data to assess the effect of the payment increase on delivery of primary care services.

## **State Experiences with Implementation: Other Research**

When considered alongside the work commissioned by MACPAC, early research is mixed on whether the primary care payment increase

affected access to primary care. On the one hand, studies in some states demonstrate that provider participation has increased concurrent with the payment increase. For example, one study found that appointment availability increased for new Medicaid patients in 10 states, even while new appointment availability did not change for privately insured patients (Polsky et al. 2015). Further, the increase in appointment availability was greater in states with larger increases in primary care payments (Polsky et al. 2015). An Ohio State Medical Association survey of providers in Ohio found that 38 percent accepted a greater number of Medicaid patients because of the primary care rate increase, although these figures should be interpreted with caution given that the survey response rate was about 8 percent (OSMA 2014). Providers in Washington attributed an increased willingness to see new Medicaid patients or to continue seeing current Medicaid patients to the payment increase (Patterson et al. 2014). Some provider associations have collected anecdotal reports that the payment increase enabled them to hire new staff or upgrade facilities (AAP 2014).

On the other hand, some states reported no change in provider participation. In fact, states interviewed by MACPAC reported that most attestations were completed by providers who participated in Medicaid prior to the payment increase. Moreover, providers may not have been aware of the provision (Crawford and McGinnis 2014). One study found that providers lacked awareness of key provisions of the increase, including requirements for physician eligibility and for Medicaid MCOs to make increased payments, and that this lack of awareness may have been greater among independent providers and providers in small groups (Patterson et al. 2014). And in Washington, 40 percent of providers did not know or were not sure whether they or their practice had received increased Medicaid primary care payments (Patterson et al. 2014).

## Evaluation

Most state Medicaid officials did not conduct their own evaluations as to whether the temporary increase in certain Medicaid physician fees had an effect on access to primary care. They noted that the complexity of the analysis—specifically, controlling for all of the changes the Medicaid program was undergoing concurrent with the increase—would be a challenge, and that they lacked staff resources to conduct such a study.

The U.S. Department of Health and Human Services has commissioned the RAND Corporation to study the issue. The RAND Corporation plans to use IMS Health physician and drug data to evaluate the effect of the provision within the context of the Medicaid expansion.<sup>13</sup> Results may shed more light on the provision's effects, but these will not be available until later in 2015.

Because there is little hard evidence to make definitive statements about the effect of the provision on provider participation and access to care at the state level or across states, it is difficult to use the experience of the temporary payment increase to inform policy decisions regarding a renewal or expansion of the provision.

## Medicaid Primary Care Rates in 2015

Even without firm evaluation results, six states (Alabama, Colorado, Iowa, Maryland, Mississippi, and New Mexico) are continuing to pay for primary care services at the Medicare level (Galewitz 2014).<sup>14</sup> These payment increases will be funded at the states' usual matching rate. Alaska continues to offer rates that are higher than Medicare as they did prior to implementation of the provision (Smith et al. 2014). An additional eight states (Connecticut, Delaware, Hawaii, Maine, Michigan, Nebraska, Nevada, and South Carolina) are continuing to pay at higher rates, although not necessarily as high as

Medicare (Smith et al. 2014, CDSS 2014, SCDHHS 2014). For example, one state interviewed by MACPAC plans to maintain primary care rates at a level halfway between the pre-2013 rates and the current Medicare rates. Although states could not quantify its effects in MACPAC interviews, some states perceived the increase to have strengthened primary care networks and improved the state's relationship with providers and wanted to maintain the momentum of these perceived effects.

Some states are expanding the eligibility of certain providers. For example, obstetricians, gynecologists, and psychiatrists in South Carolina and advanced practice registered nurses in Connecticut will be eligible for enhanced primary care payments (SCDHHS 2014, CDSS 2014).

Rates in at least 24 states reverted to their previous levels on January 1, 2015. Medicaid officials and provider organizations reported that they lacked state funds to continue offering increased rates without the enhanced federal match. Respondents in two of the five states interviewed by MACPAC reported that state legislative action to continue the rates without enhanced federal funding was defeated.

## Looking Forward

The Commission will continue to explore issues relating to the primary care payment increase and what effect, if any, this policy had and might continue having on access to primary care in Medicaid. Given that several states will continue to pay at enhanced rates in 2015 while others revert back to lower rates, we have an opportunity to examine the effects of such increases over a longer time period and possibly even compare data from states maintaining the increase with data from states that revert back to pre-2013 rates. The Commission will also continue to review any emerging research and evaluations of the primary care payment increase.

## Endnotes

- <sup>1</sup> Even though the provision was only in effect for calendar years 2013 and 2014, states have up to two years to submit claims for federal reimbursement for Medicaid services, including services eligible for the primary care payment increase.
- <sup>2</sup> A more thorough description of the statutory and regulatory provisions of the primary care payment increase can be found in MACPAC's June 2013 *Report to the Congress on Medicaid and CHIP*.
- <sup>3</sup> The three boards were the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (APS), and the American Osteopathic Association (AOA). The ABMS recognizes approximately 5 eligible family medicine, 20 internal medicine, and 20 pediatric subspecialties. The AOA recognizes 11 internal medicine and 5 pediatric subspecialties. CMS published additional information in a question and answer document (CMS 2012) and clarified in subregulatory guidance that allergists also qualify for enhanced primary care payments (CMS 2013).
- <sup>4</sup> Physicians were able to self-attest to their eligibility if at least 60 percent of their billed codes for the prior year (or the previous month, for newly participating physicians) were those to which the increased rates applied (i.e., evaluation-and-management services and vaccine-administration services and counseling related to children's vaccines). For more information, see MACPAC's June 2013 *Report to the Congress on Medicaid and CHIP*.
- <sup>5</sup> States were selected to represent a range of policy choices and health system characteristics that could affect the ease of implementation and effectiveness of the primary care payment increase. The following criteria were used: Medicaid managed care penetration rate, baseline primary care payment rates, proportion of office-based physicians accepting new Medicaid patients, proportion of the state's population living in a health professional shortage area, implementation of ACA Medicaid expansion, census region, and participation in MACPAC's first primary care payment increase interviews. West Virginia declined to participate, and Washington was interviewed instead.
- <sup>6</sup> Only two states reported having specialty and board certification information for physicians on file. Most states reported that lack of clear information from CMS on the parameters for the payment increase contributed to challenges of determining eligibility and delays in implementation. For example, states requested clarification as to whether providers in certain settings (i.e., rural health clinics, federally qualified health centers) were eligible and whether certain subspecialties were eligible. Some states also noted that as they were implementing the process necessary to identify eligible providers, CMS clarified that allergists were also eligible, which caused further delays to system modifications (CMS 2013).
- <sup>7</sup> Many of the challenges reported by states in implementing the provision within fee for service extend to managed care, including identifying eligible providers, modifying administrative systems, and coordinating attestation.
- <sup>8</sup> Provider participation has historically been considered an indicator of access to care. For more information on this, please see MACPAC's June 2013 *Report to the Congress on Medicaid and CHIP*.
- <sup>9</sup> Three states were unable to determine how many providers would have been eligible for the primary care payment increase, and therefore could not report the percentage of eligible providers who completed self-attestation.
- <sup>10</sup> Medicaid patient load for a specific provider is the share of that provider's patients who have Medicaid coverage relative to his or her share of patients with other sources of coverage or payment.
- <sup>11</sup> The increase per service was significant in most states and could be easily discerned from fee schedules. Vaccine-administration codes increased by 37 to 52 percent. The increase among three commonly billed office visit codes ranged from 23 percent to over 90 percent in three states (Michigan, Rhode Island, and Washington). On the other hand, rates for office visits in New Mexico did not increase. And the rate for a commonly billed emergency department visit code increased by more than two-thirds in four states (Michigan, Missouri, Rhode Island, and Washington). These increases should be considered cautiously in light of the fact that some states may have experienced large fee-for-service rate increases, while enrollee numbers in those programs were low compared to the high percentage of enrollees in managed care.

<sup>12</sup> The reported increase in service use was observed as an increase in the number of paid procedures provided to enrollees.

<sup>13</sup> IMS Health, Danbury, CT, is a medical and health information and technology company. A description of their information sources is available at <http://www.imshealth.com/portal/site/imshealth/menuitem.3e17c48750a3d98f53c753c71ad8c22a/?vgnnextoid=abb6e590cb4dc310VgnVCM100000a48d2ca2RCRD&vgnnextfmt=default>.

<sup>14</sup> Alabama and New Mexico were among our interviewees and confirmed that they planned to continue the primary care payment increase through 2015.

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