

Qs & As on the Increased Medicaid Payment for Primary Care

CMS 2370-F (Set IV)

May States delegate the self-attestation process to their contracted managed care plans?

Yes. A state may elect to delegate the self-attestation process to its contracting health plans under the following circumstances:

1. Each managed care plan has signed documentation on file (provider contract or credentialing application) from the eligible provider attesting to the fact that he or she has a covered specialty or subspecialty designation. This addresses step 1 of the 2-step self-attestation process specified in the rule.
2. The managed care plan has verification of the provider's appropriate Board certification (as part of the credentialing and re-credentialing process). This addresses one option of the 2nd step in the self-attestation process.
3. Should Board certification in the eligible specialty not be able to be verified by the managed care plan, the eligible provider must provide a specific attestation to the managed care plan that 60 percent of their Medicaid claims for the prior year were for the HCPCS codes specified in the regulation. This addresses a second option for the 2nd step in the self-attestation process.
4. Such delegation is included in the contract amendment that is otherwise being filed to implement this provision.

May practice managers or billing staff of large group practices and health systems attest on behalf of their physicians on the basis of information on Board certification in the records of the practice or health system?

If these practices and health systems maintain the types of documentation described in the previous answer with respect to managed care organizations, attestation by the group or system would be acceptable. As previously noted, a physician actually must be practicing as an internist, pediatrician or family physician in order to be eligible for higher payment. Board certification does not always equate to practice characteristics. Therefore, attestation on the basis of information on Board certification alone would not suffice.

If a physician renders services in both the managed care and fee for service environments, must he or she self-attest to eligibility twice?

No. The attestation and eligibility are physician-specific. If a physician provides services both in a fee for service and managed care environment, s/he need only complete the process of attestation once in order to receive higher payment for all eligible services s/he provides. CMS expects all information on self-attestation to be fully available to the state, regardless of which party collected this information.

May physicians who practice in two (or more) states meet the 60 percent threshold based on all services provided in all states, or must they qualify on the basis of the services they provide in each state?

States have the flexibility to count eligible services provided by a physician in neighboring states in meeting the 60 percent threshold, but are not required to do so.

There are at least two CPT codes (99429 and 99499) for which there are no RVUs and the State manually prices the services for purposes of Medicaid payment. Will CMS develop a Medicare-like rate for these codes?

These services would not be subject to the minimum payment standard set in the rule because there are no RVUs and there is no conversion factor associated with them. Therefore, a Medicare-like rate cannot be developed. The state may continue to reimburse them at the current Medicaid rate but enhanced FFP will not be available for those services.

CMS has indicated that the CMS-64 will be modified for states to report the expenditures that will receive the 100 percent FMAP for the increased expenditures for primary care services. Will the CMS-21 also be modified to report these expenditures for the CHIP Medicaid Expansion population?

No. The only expenditures that count against the CHIP allotment and must be reported on the CMS-21 are those related to the Medicaid rate in effect on July 1, 2009. The difference between those rates and the 2013 and 2014 Medicare rates eligible for 100 percent FMAP are Medicaid expenditures and are reported on the CMS 64.9.

As we are working to implement ACA 1202, we found that we have to pay to access the ABMS website because use of the website for business or certification is strictly prohibited. Is CMS aware of what other states are doing? Is there some other way to access this information without paying?

The state has two options: (1) it may claim this cost as an administrative expense of the Medicaid program; or, (2) it may require physicians to provide this documentation when they self-attest.

We have questions regarding how far the state should go in verifying the self-attestation of a physician should that physician be selected for the annual audit. Specifically:

- 1. if a physician self-attests to being a primary care provider and supports that attestation with evidence of appropriate Board certification, must we review that physician's practice to verify that s/he actually practices in that manner?**

No. Verification of current board certification is sufficient.

- 2. If a physician is board certified in a non-eligible specialty (for example dermatology) but practices within the community as for, example, a family practitioner and attests to meeting the 60 percent claims threshold, are we expected to audit his or her practice and, if so, how?**

Since the only evidence of eligibility is the self-attestation and claims history, the state would need to take steps to verify the practice characteristics of the physician. This could be done by determining that the physician represents himself in the community as a family practitioner, as evidenced by medical directory listings, billings to other insurers, advertisements, etc.

We would like to be specific about our audit requirements in the State plan.

While we have no objection to the addition of this information to the SPA, we believe it is more important that the state make providers aware of the audit procedures and requirements as part of the enrollment process.

There are several codes for which there are RVUs, but a rate does not calculate for the non-facility setting. For example, 99217-99221 (observation codes) only have a facility fee. If the state is electing the option of paying the non-facility fee, should it use the facility fee or is there an alternative method for calculation?

When there are RVUs for just one site of service the state should use those RVUs. There is no alternate method for calculation.

In our state, the Medicaid agency instructs Rural Health Centers (RHCs) to bill the Medicaid agency for the administration of a VFC immunization by using the provider's individual provider number for each immunization administration and the RHC/Medicaid group number for payment to the RHC for other medical services. Do RHC's not qualify for enhanced payments on E&M codes billed with the RHC Medicaid facility provider number, but the individual providers do qualify for enhanced payment on VFC administration? Given that my state also requires RHCs to bill for E&M hospital codes such as 99221 or 99223 by using the individual treating provider's number, shouldn't the individual providers be "qualifying" providers for the purpose of enhanced payments for these hospital codes?

Providers such as RHCs and Federally Qualified Health Centers (FQHCs) are reimbursed on the basis of an all-inclusive rate under their own Medicaid benefit categories. As specified in the final regulation, only services provided under the physician benefit and billed using a physician fee schedule are eligible for higher payment. In your examples, since the state reimburses the vaccine administration and the hospital codes on a fee for service basis and does not pay then all-inclusive rate, those services would be eligible for higher payment if the physician who provides

them properly self attest to eligibility. However, services provided by the physician that are reimbursed through the all-inclusive rate would not be eligible.

We interpret 42 CFR 447.205 to not require public notice of a state’s implementation of section 1202 of the ACA because “the change is being made to conform to Medicare methods or levels of reimbursement”. Does CMS interpret this regulation differently?

CMS agrees that 42 CFR 447.205(b)(1) excepts states from the public notice requirements when a change is being made to conform to Medicare reimbursement. However, states must still ensure that providers are properly notified of the requirements for self-attestation and higher payment through provider bulletins or other mechanisms.

Are the services of “physician extenders” (defined as physicians who provide services in support of eligible physicians) eligible for higher payment when an eligible primary care specialist bills for their services? Examples of “physician extenders” include neurologists, OB/GYNs, pathologists, anesthesiologists and surgeons who provide services to the patients of eligible physicians.

No. The only services that qualify are those provided directly by physicians (or by non-physician practitioners that they supervise) who self-attest to an eligible primary care designation and whose attestation is supported by evidence of Board certification or claims history. Physicians who do not qualify on their own merits cannot receive higher payment by having an eligible physician bill on their behalf. As previously noted, physicians must accept professional responsibility/liability for the services provided by non-physician practitioners under their supervision.