



AHCCCS

CLAIMS CLUES

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ENHANCED PAYMENTS TO PRIMARY CARE PROVIDERS

Background

Section 1202 of the Patient Protection and Affordable Care Act (ACA) requires state Medicaid programs to pay qualified primary care providers (PCPs) fees that are no less than the Medicare fee schedule in effect for 2013 and 2014, or the fee schedule rate that would result from applying the 2009 Medicare conversion factor, whichever is greater, for certain services designated by specific Current Procedural Terminology (CPT) codes. The enhanced payments apply only to services provided during calendar years 2013 and 2014 by qualified primary care providers, who self-attest as defined in the federal regulations. On November 6, 2012 the Centers for Medicare and Medicaid Services (CMS) published the Final Rule regarding these fee increases although CMS is still in the process of providing guidance to States regarding implementation of the Final Rule.

The information below outlines services eligible for the enhanced rates, providers who may be paid at those rates, steps providers must take to receive those increased fees, and timeframe for enhanced rate payment.

Services Eligible for Payment at the Enhanced Rates

Services eligible for the enhanced fees include Evaluation and Management (E/M) services (CPT codes 99201 - 99499) and vaccine administration procedures (CPT codes 90460, 90461, 90471, 90472, 90473 and 90474) provided to Medicaid members between January 1, 2013 and December 31, 2014. CMS is requiring changes in the way claims for vaccine administration services are submitted to state Medicaid programs. A separate memo outlining those changes will be issued and posted on the AHCCCS website.

Providers Eligible to Receive Enhanced Fees for Primary Care Services

CMS defines qualified providers for purposes of the enhanced fees for primary care services, as physicians who practice internal medicine, family practice medicine, or pediatric medicine, or any subspecialty of those three specialties recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties who meet one of the following criteria:

- 1) Physicians who are board certified in one of those specialties or subspecialties, or
- 2) Physicians who engage in the practice of one of the specialties or subspecialties described above, but are not board certified, who submit claims for services provided to Medicaid members during calendar year 2012 for which 60% of the CPT codes reported are E/M and/or vaccine administration codes described as eligible services. For newly eligible physicians, the 60% billing requirement will apply to Medicaid claims for the prior month.

Nurse practitioners (NPs) and physician assistants (PAs) who practice under the supervision of a qualifying physician will also be eligible for enhanced payments under these rules. However, in order for the NP or PA to receive the enhanced payment, the qualifying physician must submit forms to AHCCCS identifying these practitioners. CMS specifically notes that NPs who practice independently are not eligible for the enhanced fees under the ACA. CMS does not recognize other specialties, such as obstetrician/gynecologists, as primary care providers for purposes of the enhanced fees.

Actions Providers Must Take to Qualify for the Enhanced Fees

AHCCCS will post attestation forms on its website in January 2013. Physicians who practice internal medicine, family practice medicine, or pediatric medicine, or any subspecialty of those three specialties recognized by one of the professional bodies above who qualify for the enhanced fees by either being board certified in one of the qualifying specialties/subspecialties or by meeting the 60% threshold for E/M and vaccine administration code submission rates must complete the attestation form in order to receive enhanced payments. In addition, in order for the NP or PA to receive the enhanced payment, the qualifying physician must submit forms identifying these practitioners.

Providers whose attestations are received by March 31, 2013 will qualify for enhanced payments for dates of service retroactive to January 1, 2013. For attestations received on or after April 1, 2013, enhanced payments will be available for dates of service that are prospective.

CMS requires that AHCCCS conduct random, statistically valid retrospective audits of the physicians who submit attestations to confirm that they meet either the board certification requirements or the 60% code requirements. Providers subjected to such audits that fail to show they meet the requirements to which they attested are

subject to recoupment of funds paid at the enhanced rates and possible other sanctions.

Enhanced Fees

CMS is in the process of developing guidance for States to implement this final rule, which will not be available until January 2013, thus AHCCCS will provide additional information regarding the enhanced primary care payment process in the near future. The methodology and payment of the enhanced rate is predicated upon CMS approval, which could be delayed to March 31, 2013 or later. Therefore enhanced payments for qualifying claims with dates of service on or after January 1, 2013 will not begin January 1 but will be made retroactively once CMS approval is received.

AHCCCS will continue to post information on its website at: www.azahcccs.gov as it becomes available.

AGENCY WITH CHOICE *A New Member-Directed Service Option*

On **January 1, 2013**, individuals who receive attendant care, personal care, habilitation or homemaker services in their own home through the Arizona Long Term Care System (ALTCS) will have the opportunity to choose a new member-directed option known as Agency with Choice. Agency with Choice is not a separate "service" but rather it is a different way of providing these specific services that offers members the ability to play a more active role in directing their own care. For all services provided as Agency with Choice, AHCCCS will receive a 6% enhanced Federal reimbursement match.

Under the new model, the member will enter into a co-employment relationship with the provider agency. The provider will serve as the legal employer of record - maintaining the authority for hiring and firing the caregiver and ensuring that the caregiver meets the minimum training qualifications. The member will serve as the day-to-day managing employer - taking on tasks such as selecting the caregiver and determining the worker's schedule and duties. Under Agency with Choice, if someone has been appointed to help the member direct their care, that person, called the "Individual Representative", is prohibited from also serving as a member's paid caregiver.

Services provided under the Agency with Choice option, will be authorized by the member's case manager. Agency with Choice services (listed below) will be authorized with the service modifier **U7** and therefore must be billed as such in order to be paid.

Attendant Care	S5125
Personal Care	T1019
Homemaker	S5130
In-Home Habilitation	T2017
Day Habilitation	T2021
Member Training	S5108
Caregiver Training (limited)	S5110/S5115

Certain additional services when provided to members getting one of the above services will also be authorized with the U7 service modifier in order to qualify for the enhanced Federal match. Those services are as follows:

Home Modifications	S5165
Community Transition	S2038
Home Delivered Meals	S5170
Emergency Alert System	S5160/S5161

The modifier allows AHCCCS to track utilization of Agency with Choice services and claim appropriate Federal reimbursement.

Training on Agency with Choice for providers has been scheduled.

Agenda

- Overview of the Agency-with-Choice member-directed model
- Outline of member, case manager and agency roles and responsibilities
- Provider testimonials
- Review of operational considerations and protocol
- Review of the co-employment agreement between the agency and the Member

Dates/Times

Session 1	Monday, January 7, 2013	2pm	CLOSED - FULL
Session 2	Monday, January 14, 2013	2pm	CLOSED - FULL
Session 3	Thursday, January 17, 2013	10am	CLOSED - FULL
Session 4	Wednesday, January 23, 2013	10am	
Session 5	Monday, January 28, 2013	2pm	
Session 6	Thursday, February 7, 2013	10am	
Session 7	Wednesday, February 13, 2013	2pm	

Registration

To register for the webinar, please email Mark Jacquemin (Mark.Jacquemin@azahcccs.gov) and put "Agency with Choice Training" in the email subject line. Please include the following information in the email:

- Session number of the training you want to attend
- First and Last Name
- Email Address
- Agency name

More information on member-directed options is available on the AHCCCS website at: <http://www.azahcccs.gov/shared/SDAC.aspx?ID=notices>.

REMINDERS FROM UM/CM PRIOR AUTHORIZATION

Lodging Providers (provider types 55 & 56):

Effective **01/01/2013** lodging services will require prior authorization. Providers can fax lodging requests to the UM/CM Unit's FFS Prior Authorization area, with supporting documentation, using the completed Fee For Service Authorization Request form. Use of the FFS Authorization Request Form is mandatory. Faxes will be returned to the sender if this mandatory request form is not the first or second page of the faxed documentation.

Transportation Reminders:

Wait Time: wait time is billed using the code T2007, in half hour increments.