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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DATE: February 19, 2013
TO: AHCCCS Providers
FROM: Marc Leib, M.D., J.D., Chief Medical Officer
SUBJECT: Primary Care Provider Enhanced Fee Attestation for AHCCCS Registered Providers

The Primary Care Provider Attestation Form for AHCCCS registered providers is now available on line. This memo outlines the requirements for receipt of the enhanced payment in detail and how physicians can determine whether they qualify for the enhanced payments. Prior to the completion of the form, please review the information in this memo carefully.

Background

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 as primary care services and identified by specific Current Procedural Terminology (CPT) codes. In accordance with 42 CFR §447.400 services eligible for the enhanced fees are limited to Evaluation and Management (E/M) services (CPT codes 99201 – 99499) and vaccine administration procedures (CPT codes 90460, 90461, 90471, 90472, 90473 and 90474) hereafter referred to as Primary Care Eligible Services.

The enhanced payments apply only for the services described by the CPT codes listed above provided during calendar years 2013 and 2014. These services must be provided by qualified primary care providers who self-attest as required under 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.

Providers Eligible to Receive Enhanced Fees for Primary Care Services

CMS defines qualified providers for purposes of the enhanced fees for primary care eligible 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 board certified in one of those specialties or subspecialties; **or**
- 2) Physicians engaged in the practice of one of the specialties or subspecialties described above who are **not** board certified, and submitted claims for services provided to Medicaid members during **calendar year 2012** for which 60% of the CPT codes reported are E/M (CPT codes 99201 – 99499), or vaccine administration procedures (CPT codes 90460, 90461, 90471, 90472, 90473 and 90474). In addition, any claims for vaccines administered under the VFC program with the SL modifier attached to the vaccine code are counted toward the 60% requirement. For physicians who register with the AHCCCS program after December 31, 2012, the 60% requirement will apply to Medicaid claims for the prior month.

To receive the enhanced payment, CMS requires that physicians meeting one of these criteria provide a “self-attestation” to AHCCCS verifying that they qualify for the enhanced payment through either the requisite Board certification or the 60% CPT code requirement. This means that before AHCCCS can provide an enhanced payment, the physician must submit an Attestation form to AHCCCS that identifies whether they qualify for the enhanced payments because they are board certified in one of the three qualifying specialties or a subspecialty of those specialties or because 60% of the services they provided to AHCCCS members during calendar year 2012 are described by the specific CPT codes listed above identifying E/M, vaccine administration services or VFC vaccines reported with the SL modifier.

Physicians filing the required Attestation on or before April 30, 2013 will be paid the enhanced fee retroactively for dates of service from January 1, 2013 forward for all primary care eligible services. Physicians filing the required Attestation on or after May 1, 2013 will be paid the enhanced fee on a going forward basis from the time the Attestation is received.

Under the Final Rule implementing these requirements, CMS requires AHCCCS to audit the physicians submitting Attestations to determine whether they meet the requirements for the enhanced fees for primary care services. CMS requires AHCCCS to recoup all enhanced payments from physicians who attest that they meet the requirements for enhanced fees but are found to not meet those requirements in the audit.

This memo will outline those requirements in detail and how physicians can determine whether they qualify for the enhanced payments.

Board Certified in a Qualifying Specialty or Subspecialty

Physicians **currently** board certified in one of the three qualifying specialties **or** a subspecialty of those specialties recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties are eligible for the enhanced fee schedule for primary care eligible services based on their board certification. Physicians need to be board certified in either a qualifying specialty or a qualifying subspecialty, but need not be board certified in both. Physicians with a time-limited board certification that has lapsed are not eligible for the enhanced fees under this qualifying criterion. This requirement allows physicians to qualify for enhanced payments by satisfying one of the following:

1. Physicians currently board certified in internal medicine, family practice or pediatrics are eligible for the enhanced fees regardless of their subspecialty, if any. Physicians qualifying based on specialty board certification need not be board certified in the subspecialty they practice.
2. Physicians currently board certified in a recognized subspecialty of one of the three qualifying specialties are eligible for the enhanced fees based on their subspecialty board certification.

Physicians qualifying for the enhanced fees under the board certification criterion need only complete that portion of the Attestation. Physicians must be prepared to prove they meet the board certification requirement when required to do so in an audit of the Attestations.

60% of Services Provided Are Described by the Specific Primary Care CPT Codes

Physicians who practice one or more of the specialty or subspecialty designations in this memo but are not board certified are eligible for the enhanced fees if 60% of the services provided to AHCCCS members during **calendar year 2012** were described by codes identifying E/M services (CPT codes 99201–99499), or vaccine administration codes (CPT codes 90460, 90461, 90471, 90472, 90473 and 90474) based on paid claims. In addition, any claims for vaccines administered under the VFC program with the SL modifier attached to the vaccine code, are counted toward the 60% requirement as proxies for vaccine administrations under VFC during CY 2012. “Paid” claims are defined as claims submitted with the CPT codes noted above for which payment was made, including services paid at \$0.00 due to alternative payment methodologies such as sub-capitated arrangements.

The 60% threshold is calculated based on the following formula:

$$\frac{\text{Number of paid services described above}}{\text{Total number of paid services describe by all CPT and HCPCS codes}} \times 100\%$$

The value calculated above must be equal to or greater than 60%

When calculating the percentage of primary care services provided to AHCCCS members for purposes of the enhanced fee eligibility:

- The numerator is the total number of paid services provided to AHCCCS members during calendar year 2012 identified by CPT codes describing E/M services, vaccine administration services or vaccine codes with the SL modifier added.
- The denominator includes all paid services provided to AHCCCS members during calendar year 2012 identified by any CPT or HCPCS code.

The following are examples of how the percentage of qualifying services would be calculated to determine whether the physician meets the 60% primary care requirement:

Example 1: Office visit 99201–99499
VFC Vaccine 90476–90749

Total number of qualifying services	2
Total number of services	2
Percentage of qualifying services	$2/2 = 100\%$ (Meets the threshold)

Example 2: Office visit 99201–99499
VFC Vaccine 90476–90749
Urine dip stick 81000

Total number of qualifying services	2
Total number of services	3
Percentage of qualifying services	$2/3 = 66.66\%$ (Meets the threshold)

Example 3: Office visit 99201–99499
VFC Vaccine 90476–90749
Urine dip stick 81000
EKG 93000

Total number of qualifying services	2
Total number of services	4
Percentage of qualifying services	$2/4 = 50\%$ (Does not meet the threshold)

Example 4: Office visit 99201–99499
Urine dip stick 81000
EKG 93000
Antibiotic injection J0290
Syringe A4208

Total number of qualifying services	1
Total number of services	5
Percentage of qualifying services	$1/5 = 20\%$ (Does not meet the threshold)

The above are examples only. The actual calculations are not performed on a claim-by-claim basis, but rather as a single calculation. The numerator is the total of all qualifying services provided by the physician and the denominator is the total of all services provided by the physician. If the above examples represented all services provided to AHCCCS members during 2012, the numerator would be 7 (2+2+2+1) and the denominator would be 14 (2+3+4+5) and the percentage of primary care services would be 7/14 or 50%, which would not qualify for the enhanced payments.

Physicians who are not board certified in one of the qualifying specialties or subspecialties must carefully determine whether they meet the 60% threshold requirement for the enhanced fees before submitting the Attestation form. For purposes of the enhanced fee payment authorized by the federal rule, it is very important to recognize that the federal government did not include all services and CPT codes generally considered as primary care. Although urinalyses, EKGs, antibiotic administrations, and routine supplies are services commonly provided by primary care physicians, CMS did **not** include them as primary care services in the numerator when calculating the 60% threshold for the enhanced primary care fee eligibility.

Primary care physicians who see patients in the office setting every day may not qualify for the enhanced primary care fee schedule under the rules CMS established to determine eligibility for those payments. The federal Office of the Inspector General for Health and Human Services has indicated it will audit State Medicaid programs and providers who attest they meet the requirements for the enhanced payments. Failure to satisfy the audit will result in forfeiture of enhanced payments for 2013 and 2014.

Physicians who employ Nurse Practitioners (NPs) or Physician Assistants (PAs) under their direct supervision may consider combining those services with theirs for the code count. However, in these circumstances the physician must only include services for the designated CPT codes that correspond to the percentage of time that the NP or PA actually worked directly for that physician for calendar year 2012. This will only need to be considered in cases where a physician does not qualify for enhanced payments and the inclusion of NP/PA services with the physician services meets the 60% threshold requirement.

Nurse Practitioners and Physician Assistants Under the Direction of a Qualifying Physician

NPs and PAs providing services under the direction of physicians who qualify for enhanced fees will also be paid the enhanced fees for the specific CPT codes identified in this memo. To identify NPs and PAs eligible for enhanced payments, AHCCCS requires physicians filing an Attestation to identify all NPs and PAs who provide services under the direction of the attesting physician. This form is attached to the Attestation.

Although Arizona law permits NPs to practice independently and submit claims to AHCCCS for their services, CMS rules implementing the ACA specifically exclude independently practicing NPs from the enhanced payments. AHCCCS has no ability to change those rules.

Filing Attestations

Physicians can find the web-based Attestation form at the following link:

<http://azahcccs.gov/commercial/ProviderRegistration/pcpattestation.aspx>