

Qs and As on the Increased Medicaid Payment for Primary Care

CMS 2370-F (Set III)

Our understanding of the rule is that advanced practice clinicians are eligible for the increased payment as long as they are working under the personal supervision of an eligible physician; eligible meaning the supervising physician is also eligible for the increased payment. We are trying to determine if: 1) the advanced practice clinician also can attest that they are working under the personal supervision of an eligible physician at the time of attestation, or 2) if they have to indicate who the supervising physician is on each claim for an eligible service and then we would need to see if that physician is eligible for the increased payment at the time of claim processing.

If an advanced practice clinician is billing under his/her own provider number, how can we know that he or she is under the personal supervision of an eligible physician?

CMS has permitted states flexibility in establishing process to identify services provided by advanced practiced clinicians (APCs), including advanced practice nurses, being personally supervised by eligible physicians who accept professional responsibility for the services they provide. The state may set up a separate system to document that an APC is working under the personal supervision of a particular eligible physician. For example, the eligible physician could identify the APCs to the Medicaid agency, which could flag the claims submitted by those APCs under their own provider numbers through the MMIS. There is no requirement that the rendering provider indicate on each claim the name of the supervising eligible physician, however it is important that there be documentation that the eligible physician has acknowledged his relationship with the advanced practice clinicians. Providing this type of information on a per claim basis is an effective way to document the state's claim for 100 percent federal funding for the increased portion of the payment.

Are Indian Health Services excluded from the increased provider payments? Is there any change in FMAP for primary care services delivered through IHS?

IHS and tribal facilities are often not separately paid for physician services, but instead receive an all-inclusive rate for inpatient or outpatient service encounters. To the extent that a particular claim is made for primary care services furnished by an eligible physician, there is no exclusion from the requirement for provider payment at least equal to the Medicare Part B fee schedule rate. States would continue to receive FMAP at the 100 percent rate for services received through IHS and tribal facilities and reimbursed through the all-inclusive rate. For other physician services, including Medicaid payments for contract health services, states would receive the regular FMAP for the base payment, and 100 percent for the difference between the state plan rate in effect on July 1, 2009 and the applicable 2013 and 2014 Medicare rates.

The preamble of the final rule makes it clear that salaried eligible physicians employed by counties must receive the higher payment for eligible E&M and vaccine services. Does this same logic apply to physicians employed by hospitals and, if so, is it CMS's expectation that the Medicaid agency will assure that the salaries of those physicians are increased?

Physicians employed by hospitals whose services are reimbursed by Medicaid on a physician fee schedule must receive the benefit of higher payment. It is the Medicaid agency's responsibility

to ensure that hospitals receiving payments on behalf of those physicians comply with all requirements of the program. While hospitals could increase salaries they could also provide additional/bonus payments to eligible physicians to ensure that they receive the benefit of higher Medicaid payment.

The final rule clarifies that the 60 percent threshold for eligibility is based on services billed. Are billed services to be defined based on the number of units submitted or dollars?

The 60 percent threshold is based on the number of billed services as identified by individual billing codes for the primary specialty being asserted. That is, the numerator equals total billed codes for E&M services for the primary specialty, plus vaccine administration services, and the denominator equals the total number of billed codes. Please note that a state may choose to use paid billing codes/services in place of billed codes.

For evaluating the claims history, must we use all “billed” claims, including denied claims or claims that are subsequently voided? We would propose to use all paid claims net of voids and adjustments.

This is acceptable.

If a physician does not provide an attestation by a date established by the State, can the State apply the increased payment prospectively only (that is, to dates of services on and after the date of attestation)? If not, are we correct that 42 CFR 447.45(d)(1) applies such that the claim for additional reimbursement is not payable if the attestation is not received within 12 months of the date of service?

States can establish reasonable timeframes regarding the submission of attestations by physicians. We are aware that many states are experiencing delays in implementing the provisions of the regulation and we have also been made aware that there is considerable confusion on the part of providers regarding enrollment. We expect that states will provide physicians with ample notice of the procedures for enrollment that physicians will be given several months to comply with the requirements. If the state sets a reasonable timeframe, such as three months, and physicians do not enroll within that time, we believe that the state could make payment prospectively from the date of the physician’s application as long as this policy is made clear to providers.

Does a physician have to self-attest in 2014 as well as 2013? The rule does not indicate that the physician has to self-attest a second time and we don’t want to do that, but some who qualified in 2013 (based on 2012 claims history) may not qualify in 2014 (based on 2013 claims history).

You are correct that the rule does not require the physician to submit a new self-attestation in 2014 although states could impose such a requirement. States can rely on the initial self-attestation for purposes of 2014 payments since we would not expect provider practices to vary significantly from year to year.

What form must a physician use to self-attest and qualify for higher payment under this provision?

Attestation forms are developed by the State Medicaid agencies. Physicians should contact their state Medicaid agency for information on the process for becoming eligible for higher payment in their state.

While sports medicine is a subspecialty of internal medicine, it is also a subspecialty of non-primary care specialties. We would only qualify a physician for the board certification for the sports medicine subspecialty when it is a subspecialty of internal medicine. Is this correct?

Yes, that is correct.

With respect to self-attestation, if a provider only meets the 60 percent threshold or only meets the Board certification, would the provider only have to attest to that one component to be eligible or is it necessary to meet both components?

The physician must first self-attest to a primary care designation of internal medicine, family medicine or pediatrics. This attestation signifies that the physician considers himself or herself to be an eligible specialty practitioner. The self-attestation must then indicate whether the physician considers himself or herself to be qualified because of appropriate Board certification or practice history as represented by a 60 percent claims history. Some physicians may be appropriately Board certified and have a 60 percent claims history.

There may be physicians with Board certification in a specialty not recognized for higher payment under the rule who actually practice as pediatricians, family practitioners or internists who would be eligible for higher payment. For example, an OB/GYN who no longer practices in that specialty but practices as a family practitioner could appropriately self-attest to being a primary care provider. Such a provider would need to qualify based on the 60 percent threshold and not Board certification. If a physician supports his or her initial self-attestation with an attestation of appropriate Board certification, s/he can qualify only if s/he actually has the appropriate Board certification. Practice habits would not be applicable.

As we discussed in response to an earlier question, there may also be physicians with Board certification in one of the three eligible specialty areas who do not actually practice in those areas. They should not self-attest to being a primary care provider.

How should a physician who is certified in internal medicine, family practice or pediatrics by a Board other than the ABMS, the AOA or the ABPS self-attest?

Such a physician would self-attest to a primary specialty designation of family medicine, pediatric medicine or internal medicine and would then attest to, and qualify based on, a 60 percent claims history.

We understand that Deloitte (CMS's contractor) will be calculating the average GPCI values across counties for each state to use in paying primary care providers. When can we expect those values to be disseminated? Will the formula weight each county equally, or will some alternative weight be used based on county population or some other factor?

CMS disseminated the Deloitte fee for service tool to states through the CMS Regional Offices in early January. It permits states to develop rates for each code based on the decisions it makes

about site of service and geographic adjustments. The formula used to develop the rate weights each county equally and does not incorporate a weighting factor for population. Using a rate weighted by population is not an option for states to use in developing their fee schedules.

We received the Deloitte Excel model but have been unable to open some of the files. Can you help?

CMS can produce the fee schedules for states that are unable to run the program. States should contact Christopher Thompson at Christopher.thompson@cms.hhs.gov.

Community clinics in my state (clinics other than FQHCs and RHCs) are reimbursed at the same rate as a physician. They do not receive a bundled or encounter rate. Are they eligible for the higher payment? Would they have to attest that 60 percent of the services provided in the clinic are within the qualifying E&M codes? Are they required to pass through any increased payments in the form of higher wages for the health care professionals they employ?

Higher payment made under the requirements of the regulation is for physicians reimbursed pursuant to a physician fee schedule. A physician working in a clinic and reimbursed through a physician fee schedule could qualify for higher payment if he or she is appropriately Board certified or if 60 percent of the services that he or she provides is for the specified primary care services. Since the clinic itself is not eligible, this percentage of services threshold cannot be based on the aggregate of all services provided by all practitioners within the facility, only on services the individual physicians.

For physicians in neighboring states, can we require them to self-attest using our state's protocol, rather than relying on the determination made by the home state's Medicaid program?

Yes.