

Qs and As on the Increased Medicaid Payment for Primary Care

CMS 2370-F (Set II)

May providers self-attest through the use of a claims modifier? The state will issue a communication instructing providers that only those who are board-certified in a specified specialty/subspecialty or who meet the 60 percent threshold of appropriate claims history are eligible to receive the rate increase.

Can a state review providers whose claims meet the 60 percent threshold and assume that those providers would be automatically eligible?

Each physician must self-attest to being a qualified provider. It is not appropriate for a state to rely on a modifier to a claim for the initial self-attestation. Under the final rule, states are not required to independently verify the eligibility of each and every physician who might qualify for higher payment. Therefore, it is important that documentation exist that the physician himself or herself supplied a proper attestation. That attestation has two parts. Physicians must attest to an appropriate specialty designation and *also* must further attest to whether that status is based on either being Board certified or to having the proper claims history. Once the signed self-attestation is in the hands of the Medicaid agency, claims may be identified for higher payment through the use of a modifier.

If a physician presents a certificate from one of the defined boards, can the certificate be used as the legal document verifying the physician's certification or does the State have to verify with the board that the physician is certified of that the presented certificate is still active and valid?

States may accept the certificate and need not verify. The Centers for Medicare & Medicaid Services (CMS) expects states to make physicians aware that they are responsible for providing accurate information.

With respect to the use of board certification to confirm a physician's self-attestation, must the physician's board status be current or is initial board certification sufficient?

The certification must be current. If it has lapsed but the physician still practices as an eligible specialist the self-attestation would need to be supported with a 60 percent claims history.

Please clarify that if a state opts to pay out the rate increase in a lump sum payment, it must be done quarterly or more frequently and that the state plan preprint will make this clear.

The final rule specifies that such payments must be made no less frequently than quarterly, as does the final preprint issued by CMS.

CMS clarified in the final rule that, for out of state providers, the beneficiary's home state (e.g., state A) may defer to the determination of the physician's home state (e.g., state B) with respect to eligibility for higher payment. However, if states A and B receive different Medicare locality adjustments, which locality rate must be paid?

As with all Medicaid services, the state in which the beneficiary is determined eligible (state A) sets the payment rate for services. Therefore, state A would be responsible for paying using the methodology it had chosen with respect to determining the appropriate Medicare rate and would not be required to pay the rate the physician would receive from state B.

The final rule indicated that 100 percent Federal Financial Participation (FFP) is not available for stand-alone Children’s Health Insurance Program (CHIP) plans. What criteria should be used to determine if a plan is a stand-alone CHIP plan? What agency will determine if a plan is a stand-alone CHIP plan?

CMS approves CHIP programs as stand-alone or Medicaid expansions. Information on whether or not a particular state operates a stand-alone or expansion program is available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/Map-CHIP-Program-Designs-by-State-.pdf>

FQHCs/RHCs which receive an encounter rate are excluded under the rule. Are FQHCs/RHCs who are paid provider fee-for-service included in the increase?

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are required by law to be paid at least prospective payment system (PPS) for core primary care services. Physician services are core FQHC and RHC services and, therefore, should not be reimbursed on a fee-for-service basis.

In our state, advanced practice nurses must have a collaborative practice agreement with a physician within 50 miles of their office. Under the collaborative practice agreement, a physician must review a certain percentage of the nurse’s patient charts every 2 weeks. Such nurses bill independently using their own Medicaid number. Is the collaborative practice agreement enough documentation for an advance practice nurse, with at least 60 percent of services billed by the nurse for calendar year (CY) 2012 for the designated codes, to be eligible for increased payments for those codes in CY 2013?

Increased payment is available for services provided by eligible physicians or for services provided under their personal supervision. This means that the physician accepts professional responsibility (and legal liability) for the services provided. It does not appear that the collaborative arrangement requires that the physician accept professional responsibility for each of the services provided by the nurses. Therefore, increased payment would not be available.

However, if the physician *is required to accept professional responsibility* for the services provided by the advanced practice nurses *and* the *physician* is eligible based on self-attestation to a specified primary care specialty designation supported by either appropriate Board certification or a 60 percent claims history, then increased payment would be available.

If the supervising physician does not self-attest to the physician specialty or subspecialty qualification, can the physician supervise a mid-level provider? If the supervising physician self-attests to the 60 percent threshold, but not one of the defined specialty or subspecialty qualifications, can the physician supervise a mid-level?

The eligibility of services provided by mid-level/non-physician practitioners is dependent on 1) the eligibility of the physician and 2) whether or not the physician accepts professional responsibility for the services provided by the mid-level. As previously noted, the physician is eligible only if he **first self-**attests to a specified specialty designation and **also** to either being appropriately Board certified or having a 60 percent claims history.

Is it permissible for States with Medicare geographic adjustments that opt to develop rates based on the mean Medicare rate over all counties for each Evaluation & Management code to use a weighted mean based on either the county population or the county Medicaid enrollment?

We believe this would be acceptable. However, CMS would review the methodology as part of the SPA approval process.

When does CMS plan to issue a correction to the mistake they noted during the call with Medicaid agencies regarding payment at the lesser of a provider's billed charge or the Medicare rate?

The correction was published in the Federal Register on December 14, 2012. In it CMS clarified that states must reimburse providers the lower of the provider's charge or the applicable Medicare rate.

If a state were to proceed with implementation on January 1, 2013, and submit a state plan by March 31, 2013, would CMS permit the state to claim the enhanced match for services that were reimbursed at the higher rate prior to approval of the state plan?

No. As noted in the final rule, FFP in increased rates will not be available until the state plan amendment (SPA) is approved.