FAQ

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Requirements to Receive the ACA Primary Care Physician Rate Increase Overview

PROGRAM BACKGROUND

The final federal rules for implementing the primary care physician rate increase established under the Patient Protection and Affordable Care Act (PPACA) were issued in November 2012. Under Section 1202 of the PPACA (http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf), Medicaid payment for certain primary care services furnished by certain physicians in calendar years 2013 and 2014 must be at rates no less than the Medicare rates in effect in those calendar years.

PROGRAM QUALIFICATIONS

Eligibility WITH Board Certification -- To qualify for the enhanced payment, a physician must be enrolled in the Medicaid program and managed care providers must be credentialed by their managed care plan. The final rule specifies that eligible primary care providers are board certified physicians with a specialty designation of family medicine, general internal medicine, and/or pediatric medicine or a subspecialty, such as allergists, associated with the aforementioned specialties. Physicians must be board certified by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS).

Eligibility WITHOUT Board Certification -- The final rule allows physicians who are eligible primary care specialists or subspecialists, but who are not board certified, to attest that at least 60 percent of the codes billed by the physician for all of calendar year 2012 were for the evaluation and management (E&M) codes and/or vaccine administration codes specified in the regulation.

New providers must attest that at least 60 percent of the codes billed for the previous month or that they have an expectation that at least 60 percent of their codes billed in the coming month will be for E&M codes and/or vaccine administration codes. Please note that DCH will follow up to verify that the 60 percent criteria is met by the provider.

Not Eligible -- Physicians and physician extenders who are reimbursed through Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), public health departments, nursing homes or a facility's encounter (visit or per diem rate) or who are not practicing in one of the designated primary care specialties are not eligible for increased rates.

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RATE INCREASE

Increased to Medicare Rate -- The reimbursement to eligible Medicaid primary care physicians will be increased to at least the current Medicare rate for selected E&M and vaccine administration codes provided between January 1, 2013, and December 31, 2014. Services eligible for the enhanced payment are listed at https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/ACA%20CY%202013%20Enhanced%20Provider%20Payment%20Schedule%20Aug%201%20psw%20logo.pdf.

MUST ATTEST TO RECEIVE RATE INCREASE

Attestation Required -- Providers are required to attest to either being board certified in the specialties or subspecialties identified by the final rule or by noting that 60 percent of their Medicaid billings are for E&M codes and/or vaccine administration codes specified in the final rule. The Georgia Department of Community Health (DCH) will follow up to verify the 60 percent. Providers began attesting with the Georgia Department of Community Health (DCH) on May 1, 2013.

Retroactive Payments -- Providers who attest within the first 120 days of the attestation period (May 1, 2013 – August 31, 2013) will have the enhanced rate applied to all qualified claims received with a date of service on or after the January 1, 2013. Providers who attest after August 31, 2013, will receive the enhanced payment on claims beginning the month that they attest.

Please review the FAQs for further details.

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Requirements to Receive the ACA Primary Care Physician Rate Increase

Frequently Asked Questions (FAQs)

BACKGROUND

1. What is the ACA Primary Care Physician Rate Increase?

A. Effective for dates of service on and after January 1, 2013, through December 31, 2014, states are required by federal law to reimburse qualified primary care physicians for certain procedures to at least the Medicare rate of the current year. See http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf.

2. Which Medicaid providers qualify for the increased payment?

A. Physicians are eligible only if they are primary care physicians with a specialty of family medicine, general internal medicine or pediatric medicine or an associated subspecialty, such as allergists. Physicians must attest to either:

> Being board certified in the designated specialties/subspecialties by the American Board of Medical Specialties, the American Board of Physician Specialties or the American Osteopathic Association; **or**
>
> Having at least 60 percent of all codes billed by the physician for all of the previous calendar year for the E&M codes and vaccine administration codes specified in the federal regulation.

New providers must attest that at least 60 percent of the codes billed for the previous month or that they have an expectation that at least 60 percent of their codes billed in the coming month will be for E&M codes and/or vaccine administration codes. Please note that DCH will follow up to verify that the 60 percent criteria is met by the provider.

Qualification Exclusion -- The rate increases for primary care physicians are NOT available for physicians, physician assistants, advanced nurse practitioners or nurse midwives who are reimbursed through an FQHC, RHC, public health departments, nursing homes or a facility's encounter, visit, or per diem rate or who are not practicing in one of the designated primary care specialties. Refer to FFS Set III of the following CMS FAQ document: http://medicaid.gov/AffordableCareAct/Provisions/Downloads/Qs-and-As-on-1202-III-1-30-13.pdf

Qualification Exception -- There is an important exception for qualifying eligible primary care physicians to receive the rate increase. The Centers for Medicare & Medicaid Services (CMS) regulation prohibits the increase from being paid to physicians who participate in a Medicaid Supplemental Payment Program. Therefore, in Georgia, primary care physicians who receive supplemental reimbursement via the Physician Upper Payment Limit (UPL) Program are excluded

from the provider rate increase. Note -- the UPL Program provides supplemental reimbursement for physician services provided by a faculty practice affiliated with a public teaching hospital. However, the exclusion applies only to physician services billed to Medicaid fee-for-service. The exclusion does not apply to services billed to a Medicaid Care Management Organization (CMO).

3. How much is the increase?
A. The reimbursement to eligible Medicaid primary care physicians will be increased to at least the current Medicare rate for selected eligible services provided between January 1, 2013, and December 31, 2014. Please see codes listed at https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/ACA%20CY%202013%20Enhance d%20Provider%20Payment%20Schedule%20Aug%201%20psw%20logo.pdf.

ATTESTATION

4. How does a physician self-attest?
A. Eligible physicians or physician extenders must attest either via the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov or with a paper attestation form. Here are the steps to attest via GAMMIS:

1. Log onto GAMMIS (www.mmis.georgia.gov)
2. Under the menu option „Provider Enrollment," select „Provider Rate Increase Request"
3. Select „Next" on Instructions panel
4. On Increased Rate Request panel, select method of qualification – Attestation or Board Certification. Complete Fields if Board Certification selected; Select „Next"
5. Complete Attestation; Select „Submit"

Upon successful submission, tracking number is displayed; request in PDF format is displayed in separate tab; if Board Certification was chosen, a link will be provided to upload supporting documentation.

The paper attestations must be mailed to one of the two addresses listed on the form. One address is for regular USPS mail and the other is for use by overnight couriers.

5. Can someone, other than the provider, sign and date the attestation?
A. Yes. However, a notarized Power of Attorney must be submitted with the attestation. The Power of Attorney must be signed by the provider listing the name of the Authorizing Agent to sign on their behalf. An Authorizing Agent is defined as having the authority and legal power, as authorized by the provider, to execute this attestation and certification form, on their behalf. A Power of Attorney will be accepted as proof of a designated Authorizing Agent. Providers shall not

use DCH"s form, Power of Attorney for Payee, as a substitute for the Power of Attorney.

6. How does a physician who is not enrolled in Georgia Medicaid receive the ACA Provider Rate increase?

A. To be eligible to receive ACA Provider Rate Increase payments, the physician must be enrolled in Georgia Medicaid. The physician would complete the enrollment process described below and submit a copy of their attestation. Follow the attestation process as outlined in Question #4.

If the physician was not enrolled in Medicaid during the most recent full calendar year, s/he can attest that s/he is a specialist in family practice, general internal medicine, or pediatric medicine or an associated subspecialty, such as allergists, that 60 percent of claims billed provided in the previous month were for E&M codes and vaccination administration. https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/ACA%20Provider%20Rate%20Increase%20Provider%20Attestation%20Medicaid%20Billing%20Attestation%20updated%2025-06-2013%20195414.pdf.

Providers may enroll in Medicaid through the Georgia Medicaid Management Information System (GAMMIS) Web Portal at: www.mmis.georgia.gov. For expedited enrollment, providers should enroll online by:

Clicking on Provider Enrollment
Clicking on Enrollment Wizard (scroll to bottom of screen) Clicking on Provider Enrollment Application
Clicking on New Application
After the application is completed and has been submitted, you will receive an Automated Tracking Number **(**ATN) number

To upload a copy of your board certification and other required documents: Click on Provider Enrollment
Click on Enrollment Application Status
Type ATN and Last Name of Provider and click on Search
Click on Upload Required Documents
Click on pertinent Attachment Description
Attach a digital copy of your board certification and other required documents

To check the status of your application: Click on Provider Enrollment
Click on Enrollment Application Status
Type ATN and Last Name of Provider and click on Search

7. If a board certification is used to confirm a physician's self-attestation, must the physician's board status be current or is initial board certification sufficient?
A. 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 threshold of paid claims history.

8. Would out-of-state providers be required to self-attest using Georgia Medicaid protocol, rather than relying on the determination made by the home state's Medicaid program?
A. Yes. As with all Medicaid services, the state in which the beneficiary is determined eligible sets the payment rate and attestation protocol for services.

9. What form must an enrolled Medicaid physician use to self-attest and qualify for higher payment under this provision?
A. If the physician is board certified by the ABPS, AOA, or ABMS, s/he would complete the following attestation, which can be found at: https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/ACA%20Provider%20Rate%20Increase%20Provider%20Attestation%20BOARD%20CERTIFICATION%2007-05-2013%20145735.pdf.

Upon successful submission, tracking number is displayed; request in PDF format is displayed in separate tab; if Board Certification was chosen, a link will be provided to upload supporting documentation.

If the physician is NOT currently board certified by the ABPS, AOA, or ABMS but at least 60 percent of their total Medicaid billings are E&M and/or vaccine administration codes, s/he would complete the following attestation, which can be found at: https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/ACA%20Provider%20Rate%20Increase%20Provider%20Attestation%20Medicaid%20Billing%20Attestation%20updated%2025-06-2013%20195414.pdf.

The paper attestations must be mailed to one of the two addresses listed on the form. One address is for regular USPS mail and the other is for use by overnight couriers.

10. Georgia Medicaid or the CMO already has my board certification. Why do I have to attest to this again?
A. Board certification alone does not qualify a physician. The final rule requires that physicians first self- attest to practicing in the designated primary care specialties of family medicine, general internal medicine or pediatric medicine or an associated subspecialty, such as allergists, supported by either board certification or an appropriate claims history. It is important that documentation exists showing that the physician himself or herself supplied a proper attestation. States cannot pay a physician without evidence of self-attestation.

11. My board certificate does not have an end date. What shall I put in the required date field on the attestation form?
A. If your board certification does not have an end date, please put the following date into the required field: 12/31/2299.

12. The GAMMIS web portal attestation asks for my license number and I do not have one. What number should be entered?
A. If your board certification does not list a certification number, list your NPI number in the license field.

13. With respect to self-attestation, is it necessary for the provider to be both board certified and meet the 60 percent threshold components to be eligible for the enhanced payments?
A. No. Once the physician first self-attests to practicing in a designated primary care specialty, s/he then has to attest to meeting **either** the board specialty **or** 60 percent component.

14. To receive payments retroactive to January 1, 2013, by what date must the attestation form be submitted?
A. The attestation forms received prior to September 1, 2013, will result in the enhanced payment for applicable services effective for dates of service on and after January 1, 2013, unless the provider requests a later effective date. As of September 1, 2013, the effective date will be the first of the month that theprovider's attestation is received.

15. When will Georgia begin making enhanced payment for E&M services reimbursed fee-for- service?
A. GAMMIS is being reconfigured so that the claims will be automatically adjusted to make the higher payment retroactive back to January 1, 2013, for providers who attest by August 31, 2013. Otherwise, for providers who attest on September 1, 2013, or later, the primary care physician enhanced payment will be made from the first of the month in which the provider attests. The date that the higher payments will begin will be announced.

16. How will CMS and the state ensure that only eligible providers receive the higher rate?
A. Annually, Georgia must conduct a review of a statistically valid sample of physicians who have self- attested to either board certification or a supporting claims/service history. Physicians must keep all information necessary to support an audit trail for services to be reimbursed at the higher rate.

ELIGIBILITY

17. What are the eligibility requirements for physician assistants, advanced nurse practitioners and nurse midwives?

A. Increased payment for primary care services would be required for services furnished by or under the direct personal supervision of a physician who is one of the eligible primary care specialties or subspecialty types designated in the regulation. The policy does recognize the important role of physician extenders; therefore, eligible services provided by all advanced nurse practitioners, physician assistants or nurse midwives are eligible for enhanced payment.

The intent of the rule is to ensure there is direct physician involvement in the services provided. Physicians must list the physician extenders they supervise. Physician extenders will also list their supervising physicians. DCH Provider Enrollment will review documents to ensure they mirror each other. If they do, the physician extender will be deemed eligible for the enhanced payment.

Refer to the attestation for non-physician practitioners at: https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/ACA%20Provider%20Rate%20Increase%20Provider%20Attestation%20Non%20Physician%20Practitioners%2007-05-2013%20145736.pdf Additionally, on the attestation form, the supervising physician would be required to list the non-physician practitioners they supervise.

The CMS final rule specifies that services must be delivered under the Medicaid physician services benefit. This means that higher payments also will be made for primary care services rendered by practitioners working under the personal supervision of a qualifying physician. The rule makes clear that, while deferring to state requirements regarding supervision, the expectation is that the physician assumes professional responsibility for the services provided under his or her supervision. This normally means that the physician is legally liable for the quality of the services provided by individuals he or she is supervising. If this is not the case, the practitioner would be viewed as practicing independently and would not be eligible for the rate increase.

18. Are subspecialists eligible for higher payment?
A. Yes. Subspecialists who may qualify for higher payment are those recognized by the ABMS, ABPS, or the AOA and eligible for enrollment as providers in Georgia Medicaid.

Also refer to page 2 of the CMS FAQ document, *Increased Medicaid Payments for PCPs,* available at:

http://medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html

19. Do physicians practicing in clinics or hospitals qualify for higher payment?
A. Higher payment does not apply to primary care services that are reimbursed on the basis of an all- inclusive rate, such as FQHCs, RHCs and free standing RHCs (no separate physician billing allowed). Since physician services are not included in hospital inpatient or hospital outpatient clinic rates in Georgia, these physician services **will** qualify for the higher payment.

20. Do non-physician practitioners practicing in clinics or hospitals qualify for higher payment?
A. The ACA Provider Rate Increase does not result in any changes in billing policy for professional services provided in these settings. Higher payment does not apply to primary care services that are reimbursed on the basis of an all-inclusive rate (no separate practitioner billing allowed). If the physician assistants, advanced nurse practitioners and nurse midwives services are not included in hospital inpatient or hospital outpatient clinic rates, these services **will** qualify for the higher payment.

21. Can I qualify if I am not board certified in a designated primary care specialty?
A. Yes, but such a provider would need to qualify based on the 60 percent threshold and not board certification.

22. Do I automatically qualify for the enhanced payment if I am board certified in a designated primary care specialty?
A. No. There are no "automatic qualifications." Eligible practitioners must self-attest to being an eligible primary care provider to receive the enhanced payment. Here is the link to the form: https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/ACA%20Provider%20Rate%20Increase%20Provider%20Attestation%20Medicaid%20Billing%20Attestation%20updated%2025-06-2013%20195414.pdf

23. How will the providers know which primary care services will be paid at the higher rate?
A. The regulation at 42 CFR 447.000(c)(1) and (2) specifies E&M codes 99201 through 99499 and vaccine administration codes 90460, 90471, 90472, 90473, or their successor codes, will be paid at the higher rate. Please see chart at https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/ACA%20CY%202013%20Enhance d%20Provider%20Payment%20Schedule%20Aug%201%20psw%20logo.pdf.

24. If a physician renders services in both the managed care and fee-for-service environments, must s/he self-attest to eligibility twice?
A. 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 needs only to complete the process of attestation once to receive higher payment for all eligible services s/he provides.

QUALIFIED SERVICES AND PAYMENT

25. What services are eligible?
A. Services eligible for the enhanced payment include E&M codes between 99201 and 99499 and vaccine administration codes 90460, 90471, 90472, 90473, or their successor codes.

26. Does the 60 percent threshold include both Evaluation and Management (E&M) codes and vaccine administration codes?

A. Yes. The 60 percent threshold can be met by any combination of eligible E&M and vaccine administration codes. DCH will follow up to verify the 60 percent provision is actually met by the provider. If the provider fails to meet the 60 percent threshold, then DCH will recoup the payment.

27. Is a state required to cover all of the primary care service billing codes specified in the regulation and then reimburse all qualified providers at the Medicare rate in CYs 2013 and 2014?

A. Georgia is NOT required to cover all of the primary care service billing codes if it did not previously do so. Rather, to the extent that it reimburses physicians using any of the billing codes specified in the final rule, the state must pay at the Medicare rate in CYs 2013 and 2014.

28. Does higher payment apply to PeachCare for Kids?

A. No. The higher payment does **not** apply to primary care services for beneficiaries enrolled in PeachCare for Kids®.

29. Are eligible E&M and vaccination codes that are covered by managed care health plans but not under the Medicaid State Plan eligible for reimbursement at the enhanced Medicare rate?

A. No. The only codes that are eligible for reimbursement at the Medicare rate as specified under the final rule are those eligible codes that are identified under the Medicaid State Plan. Additional E&M or vaccination administration codes that are being "covered" by a health plan, but that are not identified in the state plan, cannot be reflected in the increased rates.

30. Are CMOs permitted to include amounts sufficient to account for the payment differential on expected utilization while still holding the sub-capitated primary care physicians at risk for some level of increase in utilization due to the higher rates? Or must CMOs remove the risk to primary care physicians for utilization to ensure that these physicians receive the increased amount for actual experience?

A. The purpose of section 1202 of the Affordable Care Act and the final rule are to ensure access to and utilization of beneficial primary care services. Toward that goal, eligible primary care physicians must receive the full benefit of the enhanced payment at the Medicare rate for eligible services rendered. If a Medicaid managed care health plan retains sub-capitation arrangements, the health plan would be obligated to provide additional payments to providers to ensure that every unit of primary care services provided is reimbursed at the Medicare rate. Refer to page 2 of the CMS FAQ document, Managed Care Set II, available at: http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Qs-and-As-on-1202-III-1-30-13.pdf

31. How are case management fees in Primary Care Case Management (PCCM) programs affected by this rule?

A. PCCM payments are not eligible for higher payment under this rule.

32. Will retroactive provider payments by health plans necessitated by the state's retroactive payment of the higher rates to health plans be subject to timely claims filing requirements in 42 CFR 447.46?

A. Any retroactive payments made to providers to ensure that eligible providers receive the applicable Medicare rate for eligible services will not be considered claims subject to the timely claims filing requirements in 42 CFR 447.46, *Timely Claims Payment by MCOs.*