

MEDICAID PRIMARY CARE RATE INCREASE FAQs
(Version 5, July, 2013; new information italicized in red)

Self-Attestation

- Q. Which Medicaid providers qualify for the primary care rate increase?
- A. **The following is CMS guidance. The statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. Under the regulation, “general internal medicine” encompasses internal medicine and all subspecialties recognized by the ABMS, ABPS and AOA. In order to be eligible for higher payment:**
- 1) Physicians must first self-attest to a covered specialty or subspecialty designation.**
 - 2) As part of that attestation they must specify that they either are Board certified in an eligible specialty or subspecialty and/or that 60 percent of their Medicaid claims for the prior year were for the E&M codes specified in the regulation. It is quite possible that physicians could qualify on the basis of both Board certification and claims history.**

Only physicians who can legitimately self-attest to a specialty designation of (general) internal medicine, family medicine or pediatric medicine or a subspecialty within those specialties recognized by the American Board of Physician Specialties (ABPS), American Osteopathic Association (AOA) or American Board of Physician Specialties (ABPS) qualify. States cannot pay a physician without evidence of self-attestation.

- Q. Can physicians qualify solely on the basis of meeting the 60 percent claims threshold, irrespective of specialty designation? Would a Board certified “general surgeon” qualify for higher payment if he or she actually practices as a general practitioner?
- A. **The following is CMS guidance. It is possible that a physician might maintain a particular qualifying Board certification but might actually practice in a different field. A physician who maintains one of the eligible certificates, but actually practices in a non-eligible specialty should not self-attest to eligibility for higher payment. Similarly, a physician Board certified in a non-eligible specialty (for example, surgery or dermatology) who practices within the community as, for example, a family practitioner could self-attest to a specialty designation of family medicine, internal medicine or pediatric medicine and a supporting 60% claims history. In either case, should the validity of that physician’s self-attestation be reviewed by the state as part of the annual statistical sample, the physician’s payments would be at risk if the agency finds that the attestation was not accurate.**

Q. What are the eligible board certifications and subspecialties that qualify providers for the primary care rate increase?

A. The list of eligible board certifications and subspecialties are attached to the December 28, 2012 Medicaid Memo on the Virginia Web Portal at www.virginiamedicaid.dmas.virginia.gov. *On July 1, 2013, CMS communicated that all physicians certified by the Board of Allergy and Immunology are also eligible for higher payments because they are subspecialists of internal medicine or pediatrics.*

Q. Will DMAS audit self-attestations?

A. DMAS is required to audit a statistically valid sample of physicians that have self-attested to either Board certification or a supporting claims/service history. Higher payments for both FFS and MCO services will be recovered from physicians who the audit determines were not eligible.

Q. For physicians attesting that 60 percent of their Medicaid claims for the prior year were for the E&M services and vaccine administration, how will DMAS evaluate if the physician met the criteria during an audit?

A. DMAS will include all Virginia Medicaid claims paid by FFS and MCOs during the most recently completed calendar year or, for newly eligible physicians, the prior month. No FAMIS claims will be included. Primary care services are all the codes covered by the higher payments, including vaccine administration codes. In the case of adjustments, only the final adjudicated claim will be counted.

Q. If I meet both criteria (board certification and a primary care claims history), can I or should I attest to both criteria?

A. Physicians may attest to meeting both criteria, but it is not necessary. If a physician who has attested to both criteria is chosen for an audit, DMAS will first evaluate if the physician meets the board certification criteria and will not evaluate the primary care claims history unless the physician does not meet the board certification criteria.

Q. If I am part of a group practice, can the group practice attest for me?

A. No. Each physician must separately attest.

Q. If I am a nurse practitioner or a physician assistant, am I eligible to receive higher payments for eligible primary care services? If yes, how do I attest?

A. Services furnished “under the personal supervision” of an eligible physician are eligible for higher payments. DMAS received the following guidance from CMS. The final rule specifies that services must be delivered under the Medicaid physician services benefit. This means that higher payment 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 is supervising. If this is not the case, the practitioner would be viewed as practicing independently and would not be eligible for higher payment. DMAS enrolls independent Nurse Practitioners, who may furnish services without the personal supervision of a physician. In order to insure that DMAS makes higher payments only for services furnished under the personal supervision of an eligible physicians, DMAS will only pay higher rates for eligible services furnished by Nurse Practitioners when billed under the NPI of the supervising physician who is eligible for the higher payments. Nurse Practitioners may not attest or bill for the higher rates using their own NPI. This policy also applies to Physicians Assistants who are only enrolled by DMAS for crossover claims or who may be enrolled with managed care plans.

Q. Are physicians practicing in FQHCs and RHCs eligible for higher payment?

A. Higher payment does not apply to services furnished as part of an FQHC or RHC.

Q. If I furnish primary care services in a health department clinic, am I eligible to receive higher payments for eligible primary care services? If yes, how do I attest?

A. Services furnished by Health Department clinics are not eligible for higher payments. However, clinic physicians who are enrolled or wish to enroll separately and attest are eligible. If the services are billed as physician services, DMAS will pay the higher rates.

Procedures For DMAS Enrolled Providers

Q. Where can I obtain the Virginia Medicaid Certification and Attestation Form?

A. The certification and attestation form can be found on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov. Please use the form for DMAS Enrolled Providers.

Q. Where do I submit Virginia Medicaid Certification and Attestation Form to Virginia Medicaid for processing?

A. **The completed certification and attestation form can be submitted via fax at 888-335-8476 or via United States Postal Service to Virginia Medicaid Provider Enrollment Services P. O. Box 26803, Richmond, VA 23261-6803**

Q. How long will it take to process the certification and attestation form?

A. **The Virginia Medicaid provider enrollment services department will process all attestation forms within 10 business days from receipt.**

Q. Is there a deadline for self-attestation?

A. ***There is no deadline. However, any physician who completes the self-attestation on or before March 31, 2013 will be eligible for higher payments for dates of service on or after January 1, 2013. After March 31, 2013, physicians will be eligible for higher payments for dates of service on or after the beginning of the month of self-attestation. The date of attestation will be based on the date received if mailed or the fax date if faxed. Physicians are encouraged to attest as soon as possible to make sure they receive the additional payments if they qualify.***

DMAS only recently received information from CMS that all physicians certified by the Board of Allergy and Immunology are also eligible for the higher because they are subspecialists of internal medicine or pediatrics. If these physicians attest prior to September 30, 2013, they will be eligible for higher payments for dates of service on or after January 1, 2013. In order for DMAS to identify these attesting physicians for special treatment, physicians must also check the box that they are certified by the American Board of Allergy and Immunology. If that box is not checked or the physician does not attest until after September 30, 2013, DMAS will follow its normal policy and make higher payments for services only from the beginning of the month of attestation. DMAS will accept attestations from physicians who are certified by the American Board of Allergy and Immunology through September 30, 2013 regardless whether they are DMAS enrolled or participate only with one or more managed care networks.

Q. If I am a primary care physician but I am not currently enrolled in Medicaid with DMAS, how do I enroll?

A. **Please contact the Provider Enrollment Unit at 888-829-5373 or complete the Physician enrollment application and the attestation form. The forms are available at www.viriniamedicaid.dmas.gov.**

- Q. Can prospective providers submit the certification and attestation form for the primary care rate increase with their application for enrollment in Virginia Medicaid?
- A. **Yes, prospective providers who are applying for enrollment in the Virginia Medicaid program can submit the completed certification and attestation form with their application for enrollment. Newly enrolled providers will also be furnished information about attestation when they receive the enrollment package.**
- Q. How will I know when this form has been processed and I am eligible for the primary care rate increase?
- A. **Once your certification and attestation form has been received and processed by the Virginia Medicaid Provider Enrollment Services unit, your name will be added to the weekly report that is posted on the Virginia Medicaid Web Portal www.virginiamedicaid.dmas.virginia.gov.**
- Q. Who do I contact if I have questions regarding the attestation form and submission process?
- A. **The “HELPLINE” is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The “HELPLINE” numbers are 804-786-6273 in the Richmond area or out-of-state or 800-552-8627 for all other in-state localities (toll-free long distance). Please remember that the “HELPLINE” is for DMAS enrolled providers only. Please have your Medicaid Provider Identification Number available when you call.**
- Q. What do I do if I attest but subsequently determine that I no longer meet the attestation requirements?
- A. **Please contact the Virginia Medicaid Provider Enrollment Services Unit at 888-829-5373.**

Managed Care Related Attestation Questions

- Q. If I am a DMAS enrolled provider and I also participate in one or more Medicaid MCO provider networks, do I also have to submit a separate attestation to each Medicaid MCO?

A. If you are a DMAS enrolled provider, DMAS will share the attestation with each Medicaid MCO. You do not need to submit an attestation to the MCOs you participate with.

Q. If I am not a DMAS enrolled provider but I participate in a Medicaid MCO network, can I still submit an attestation to DMAS? If not, where do I submit an attestation?

A. DMAS is only accepting attestations from DMAS enrolled providers. If you are not a DMAS enrolled provider, you should be contacted by each MCO whose network you participate in. MCOs will have procedures similar to DMAS.

For Virginia Medicaid MCO related questions, please go to the following DMAS website for more information: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

Medicare Fee Schedule

Q. What codes are eligible for the increase?

A. The services eligible for the payment increase include covered evaluation and management (E&M) procedure codes between 99201 and 99499, and vaccine and toxoid administration procedures. Only codes in this range covered by DMAS FFS are eligible for payment of the higher rates. The rate file published at www.virginiamedicaid.dmas.virginia.gov lists all the covered codes. Other codes that may be covered by Medicaid managed care plans are not eligible for the higher payment.

Q. How will the Medicare E&M rates effective on January 1, 2013 be calculated?

A. The rates for the covered E&M procedures will be calculated with the calendar year (CY) 2013 Medicare relative value units (RVUs) in effect as of January 1, 2013 and the 2009 Medicare conversion factor (CF). The law requires this rate calculation if the resulting rates are higher than the Medicare rates effective January 1, 2013.

Q. Will DMAS update rates for E&M codes during the year when Medicare updates these rates?

A. DMAS will not update the rates during the year.

Q. Will DMAS pay rates based on site of service and geography the same as Medicare?

A. DMAS will pay office rates for all services regardless of the site of service. DMAS will pay separate rates for Northern Virginia and Rest of State.

Q. What will the rate be for vaccine administration for Vaccines for Children?

A. The rate for vaccine administration for the Vaccines for Children (VFC) program will increase from \$11.00 per administration to \$21.24, which is the VFC regional maximum amount specified in the CMS final rule.

Q. Will any DMAS billing changes be required to qualify for the rate increase?

A. Yes. DMAS requires providers to use different procedure codes for vaccine administration for the VFC program than the codes covered in the CMS final rule. DMAS will pay the higher rate on the current procedure codes used for vaccine administration. Providers must bill at least \$21.24 for each vaccine administered to be eligible for the full amount of the rate increase and must adjust claims with dates of service on or after January 1, 2013 to receive the increase. Please review the vaccine billing guidance Medicaid Memo posted on the Virginia Web Portal at www.virginiamedicaid.dmas.virginia.gov.

Q. When will the rates be available and where will the rates be posted?

A. DMAS has published the rates on the Virginia Web Portal at www.virginiamedicaid.dmas.virginia.gov.

Q. Does the rate increase for vaccine administration apply to all providers or only primary care providers?

A. The rate increase for vaccine administration only applies to primary care physicians that are enrolled in the Vaccines for Children program and meet the eligibility criteria for the primary care rate increase.

Q. Are these higher rates permanent?

A. The Medicaid primary care rate increase is effective for dates of service on or after January 1, 2013 through December 31, 2014.

Q. What rates will I be paid if I am an out-of-state provider?

A. Physicians in the Washington-Maryland-Northern Virginia Medicare physician rate region will be paid the Northern Virginia rates. All other out-of-state providers will be paid the Rest of State rates.

Q. What rate will be paid for Medicare crossover claims (claims where Medicare is the primary payer)?

A. DMAS will pay up to the full copayment and deductible as long as the total payment from Medicare and Medicaid does not exceed the rate under the Medicaid primary care rate increase. Some claims for which DMAS made no payment initially will receive a payment.

FFS Payments

Q. What services are eligible for the higher rate?

A. Eligible Medicaid E&M services and vaccine administration furnished by eligible physicians are eligible for the higher rates. FAMIS services are not eligible for the higher rate but claims for Medicare crossover services are eligible.

Q. How will DMAS pay the higher rate?

A. DMAS will not pay eligible claims at the higher rate, but at the current Medicaid rate. On a quarterly basis, DMAS will calculate lump sum supplemental payments reflecting the difference between the Medicare rates and the rates paid on claims during that quarter. CMS has approved the State Plan Amendment for the primary care rate increase. DMAS will make the first FFS supplemental payments covering the first six months of CY13 to eligible providers in the remit of July 19. Providers who attested successfully on or before March 31, 2013 will receive payments for dates of service from January 1, 2013. Providers who attested after March 31st are eligible for payments beginning the 1st day of the month in which they successfully attested (i.e. - A provider who attested on April 7th would be eligible for payments based on claims with service dates on or after April 1st). After this catch up payment, future payments will be made quarterly.

Q. So I can expect the remittance advice to list one payment representing the lump sum quarterly supplemental payment for the Medicaid primary care rate increase?

A. There will be up to four “add payments” on each remittance advice with the lump sum quarterly supplemental payment. These four add payments are related to

funding source, which is necessary for DMAS accounting. The funding source does not affect the payment.

- Q. Will the lump sum quarterly supplemental payments be included in my regular remittance and remittance advice?
- A. **The additional payments will be included on your remittance for the week that the payment is made. The remittance advice will have up to four lines based on the funding source. No detail linking the lump sum quarterly supplemental payments to the specific claims from which they were calculated will be included.**
- Q. Will I receive claims level detail so that I can reconcile my claims to the total payments?
- A. **DMAS will make available the claims detail in a detailed claims report. ~~DMAS has not yet determined how to make the report available to providers.~~ The detail will include the calculated additional amount and information to reconcile to the original paid claim. *Detailed claims reports will be available to billing providers on the web portal in the same manner that remittance detail is available. See the link to instructions on retrieving the detailed claims information.***
- Q. How long will I receive lump sum quarterly supplemental payments?
- A. **The Medicaid primary care rate increase is effective for dates of service on or after January 1, 2013 through December 31, 2014. The lump sum quarterly supplemental payments will continue as long as there are original claims, adjustments or voids for services furnished on or after January 1, 2013 through December 31, 2014.**

Managed Care Payments

- Q. How will MCOs make higher payments?
- A. **MCOs will contact their eligible providers with information on how the higher payments will be made. MCOs must pay the higher rates for eligible services to eligible physicians but they are not required to use the same payment methodology as FFS. *Each MCOs plan to make payments is available at the link below.* Please contact the managed care plan *directly* if you have any questions.**

For Virginia Medicaid MCO related questions, please go to the following DMAS website for more information: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.