

## Primary care reimbursement changes under the ACA

In November, the Centers for Medicare and Medicaid Services (CMS) announced that practitioners who meet their new definition of primary care provider would see an increased Medicaid reimbursement rate for two years under [section 1202 of the federal Affordable Care Act](#) (ACA).

This fact sheet describes how the Division of Medical Assistance Programs (DMAP) will implement the fee-for-service (FFS) rate increase. OHP health plans (MCOs and CCOs) will develop their own processes for providers on their panels who do not bill DMAP. We are confirming with CMS whether plans need to follow the same attestation and payment timelines as DMAP.

### Oregon's definition of primary care provider will not change

Oregon is not changing its definition of Medicaid primary care provider. Instead, Oregon will add the CMS definition alongside Oregon's definition in order to identify primary care providers who qualify for the new two-year reimbursement increase.

This is a decision at the federal level. The CMS definition only determines which providers may qualify for the two-year reimbursement increase; it does not reduce or change reimbursement for other providers or programs. Oregon's primary care providers who meet CMS's definition will receive an enhanced rate for two years, those who do not will receive their [existing primary care rate](#).

### What providers need to do

Providers who bill DMAP can now self-attest to meeting the new definition in order to receive the increased FFS reimbursement rate for calendar years 2013 and 2014.

Please attest using the [secure attestation form](#). Only providers who attest using this form will qualify for the increased FFS rate. Providers who do not attest will not qualify for the increased FFS rate.

**Please Note:** Providers who only bill an OHP health plan (MCO or CCO), but not DMAP, must attest with the plan.

We strongly encourage providers and plans [to sign up for e-mail updates from DMAP](#) to find out when we are ready to process FFS claims at the higher rates for qualified primary care providers.

### What is the rate increase and when is it happening?

CMS has established the following services as qualifying for the higher rate. However, DMAP will only pay the higher rate to providers who qualify under the new definition. In addition, DMAP will only pay the higher rate for codes that are currently open for payment.

DMAP plans to update the system with the new FFS rates on or after May 1, 2013 (pending CMS approval).

Qualifying codes	New 2-year rate under ACA Section 1202
CPT E/M codes 99201 through 99499	The new rates will use Medicare's 2009 factor of \$36.0666 multiplied by the 2013 Relative Value Unit (RVU) weights.
Adult vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors.	The rate will also include aggregated Geographic Practice Cost Indices for the three components of work (1.0), practice expense (0.969), and malpractice (0.625):

DMAP plans to apply the rates based on the dates qualified providers submit their attestations. Only services rendered on or after Jan. 1, 2013 qualify for the new rates:

Attestation submitted	Increased FFS rate will apply to qualifying services rendered on or after:
Jan. 1 to Mar. 31, 2013	Jan. 1, 2013
Apr. 1 to June 30, 2013	Apr. 1, 2013
July 1 to Sep. 30, 2013	July 1, 2013
Oct. 1 to Dec. 31, 2013	Oct. 1, 2013

MCOs and CCOs will develop their own process to determine appropriate primary care payment for their provider panels..

### How will providers qualify as a primary care provider under the new definition?

To qualify, all physicians must self-attest that they are practicing in Family Medicine, General Internal Medicine<sup>1</sup>, or Pediatric Medicine, including specialties and subspecialties within those designations as recognized by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), or American Board of Physician Specialties (ABPS).

Physicians must also attest that:

- 60 percent of their codes billed in Medicaid claims for the prior year were for the qualifying primary care codes (E/M and vaccine administrations, including [Vaccines for Children](#) administrations using the SL or 26 modifier); **OR**
- They are certified in an eligible specialty or subspecialty by ABMS, AOA, or ABPS:
  - ABMS member boards include the American Board of Family Medicine, the American Board of Internal Medicine, and the American Board of Pediatrics. Other member boards may also qualify if they are related to General Internal Medicine, Family Practice, or Pediatric Medicine.
  - For a full list of member boards, visit [www.abms.org/about\\_abms/member\\_boards.aspx](http://www.abms.org/about_abms/member_boards.aspx).

Physician assistants and nurse practitioners must self-attest that they work under the direct supervision of a qualifying physician as described above.

DMAP will provide an attestation form for providers who bill DMAP and would like to receive the increased FFS rate. Plans will develop their own process for providers on their panels who do not bill DMAP.

### If a physician is Board-certified in another specialty not listed above and meets the 60 percent requirement, can they qualify for the rate increase?

Only physicians **who practice** Family Medicine, General Internal Medicine or Pediatric Medicine or any subspecialty within these specialties are eligible for the rate increase.

<sup>1</sup> “General internal medicine” encompasses internal medicine and all subspecialties recognized by the ABMS, ABPS and AOA.

- If a physician is Board-certified in another specialty (*e.g.*, surgery), but **practices** Family Medicine, General Internal Medicine or Pediatric Medicine, and meets the 60 percent requirement, he/she is eligible for enhanced payment.
- If the physician is Board-certified in another specialty, but **does not practice** in one of the qualifying specialties, and meets the 60 percent requirement, he/she is not eligible for the enhanced payment.

### **What process will be in place for newly enrolled physicians who are not Board-certified and who do not have sufficient claims history with Medicaid?**

A new physician who practices Family Medicine, General Internal Medicine or Pediatric Medicine must meet the 60 percent requirement during at least one full month of paid claims history with Medicaid.

### **Where can I learn more?**

For more information about the new enhanced payment:

- [Section 1202 of the Affordable Care Act \(ACA\)](#)
- [Federal Register/ Vol 77, No 215 published on November 6, 2012](#), and the [December corrections to the Federal Register](#), establishing revisions required by ACA Section 1202
- [CMS questions and answers](#)

For more information about Oregon's definition of Medicaid primary care or other programs

- [Oregon's definition of Medicaid primary care providers](#)
- [Description of Oregon's Medicaid fee-for-service payment rates](#)
- [Patient-Centered Primary Care Home Program](#)