

Questions and answers about primary care reimbursement changes under the ACA

This document lists questions received during DMAP's February webinars about the federal 2013-2014 primary care reimbursement rate increase. Questions marked with an asterisk (*) have answers that DMAP has updated since the webinar. Other common questions DMAP has received are also answered here.

- [General information, qualifying codes and providers](#)
- [How to attest to qualifying for the increase](#)
- [How the rate increase will apply](#)
- [Information for OHP health plans \(MCOs and CCOs\)](#)

General information, qualifying codes and providers

Where can we find the PowerPoint presentation from the webinars?

We will post it on DMAP's new Web page about primary care reimbursement under ACA Section 1202. A video of the webinars will also be available on the [OHA YouTube channel](#).

What are the primary care codes?

[A list](#) of the eligible codes paid by DMAP is available on our Web page at http://www.oregon.gov/oha/healthplan/pages/tools_prov_pcp-rates.aspx.

Which providers may qualify?

Physicians need to be practicing in Family Medicine, Pediatric Medicine or General Internal Medicine and either be certified by an eligible Board (listed below), or have 60% of their Medicaid-paid codes as eligible primary care codes.

Nurse practitioners (NPs) and physician assistants (PAs) need to be under the direct supervision of a qualified physician.

Both physicians and NPs/PAs need to [self-attest that they qualify](#) in order to qualify for the increased rate.

What do you mean by “eligible Board”?

The Family Medicine, General Internal Medicine, and Pediatric Medicine specialty and subspecialty designations eligible for the increase are those recognized by the following Boards:

- American Board of Medical Specialties (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 relating to family medicine, general internal medicine, or pediatric medicine also qualify. For a full list of member boards, visit www.abms.org/about_abms/member_boards.aspx.
- American Osteopathic Association (AOA), or
- American Board of Physician Specialties (ABPS).

“General internal medicine” encompasses internal medicine and all subspecialties recognized by the ABMS, ABPS and AOA.

If you are not certified by one of these three Boards, you will need to attest to meeting the 60 percent requirement.

You say that to qualify, you need to be Board-certified in an eligible specialty or subspecialty, or have 60 percent of codes paid be eligible codes. Please clarify.

First of all, only providers who self-attest will qualify. If you do not self-attest, you will not qualify.

If you are not certified by an eligible Board in one of the eligible specialties or subspecialties, then you can self-attest that 60 percent of the codes paid you by Medicaid were eligible primary care codes. In either case, physicians must also attest that they currently practice in a covered specialty or subspecialty.

If you are audited, you must be able to document that you are certified by an eligible Board in one of the eligible specialties, **or** that 60 percent of the codes paid by Medicaid are eligible primary care codes.

Our NPs bill directly under their DMAP number and are supervised by our physicians. Would the NP be eligible?

Yes, if the supervising physician has [attested with DMAP](#) that they practice Family Medicine, General Internal Medicine or Pediatric Medicine; and are either Board-certified or have 60 percent of their Medicaid-paid codes as eligible primary care codes.

Can mental health NPs and physicians attest, since some mental health codes changed to E/M in 2013?

Yes. Mental health practitioners would need to qualify using the same criteria as other practitioners.

To qualify for the increase, does an NP who practices Family Medicine still have to be under the supervision of a physician? In Oregon, NPs don't have the same supervisory requirements as a physician assistant (PA), so that doesn't seem fair.

This is correct. Even though independently practicing NPs are recognized in Oregon as primary care providers, and are paid Oregon's primary care rate, they do not qualify for the federal primary care rate increase.

According to CMS, the statute from Congress only allows a physician (or someone working under the direct supervision of a physician) to qualify for this increase.

We regret this and understand that it doesn't seem fair, but we need to comply with this federal requirement.

Are practitioners who practice in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) eligible? *

According to CMS, the increase does not apply to FQHCs, RHCs or tribal clinics (Indian Health Services or Tribal 638 clinics).

Practitioners who practice only in an FQHC, RHC, or tribal clinic would not be eligible. If a practitioner practices in other settings in addition to the FQHC, RHC, or tribal clinic, they may attest; however, the increase would only apply to services billed to DMAP for services not delivered in an FQHC, RHC or tribal clinic. If attesting to 60 percent paid codes, physicians could only attest to services delivered outside the FQHC, RHC or tribal clinic setting.

Do Public Health Clinics who work under standing orders qualify? Do county health departments qualify as Public Health Clinics or Family Planning Clinics?

Clinics do not qualify, but their practitioners might. If the practitioner is working at a clinic and qualifies as stated above, then they need to [self-attest](#) in order to qualify for the increased rate.

The primary care codes list includes provider types, including clinic types, such as public health clinics. Will you clarify what you mean by practitioner-level eligibility when clinics are included?

The code list you are referring to is for [Oregon's existing primary care definition](#), which is not changing. Please do not confuse Oregon's definition with the federal definition under the ACA.

The federal definition under the ACA qualifies you for a higher primary care rate than Oregon's. Oregon's primary care definition is broader and includes clinics, but not all providers under that definition will qualify for the federal increase.

Do hospital-based providers (hospitalists) who practice in a qualifying specialty and meet the 60 percent requirement for inpatient services qualify? They will have the same credentials and coding as primary care providers.*

Practitioners employed by hospitals whose services are reimbursed by Medicaid on a physician fee schedule and billing in the professional claim format would receive the higher payment.

Practitioners employed by hospitals whose services are reimbursed by Medicaid on a hospital fee schedule and billing in the institutional claim format would not be eligible for the higher payment.

Hospitalists are generally employed by the hospital and billings are included on the institutional claim, not a professional claim. These providers would not be eligible for the higher payment as expressed above.

To clarify, would a provider with a Family Medicine designation who practices full time in the emergency department (ED) be eligible? ED codes are included in the eligible code range.*

If the provider attests to primarily practicing Family Medicine, General Internal Medicine or Pediatric Medicine; and attests to either being Board-certified, or to 60 percent of Medicaid-paid codes being eligible for the increase, they would receive the increase.

There is nothing in the rule about place of service. Where you provide service does not determine how you qualify, except as discussed regarding FQHC/RHCs. When the claim processes, it will not look at place of service, just that the eligible practitioner is on the claim.

Please note that the increase will only apply to professional (not institutional) claims.

Is the 60% requirement 60% of the number of codes, not 60% of revenue?

Correct. It is 60% of paid codes. It isn't about your practice revenue, but total number of codes you are paid on and what percent of those are qualifying E/M or vaccine administration codes.

DMAP covers more codes as primary care than are covered by the ACA primary care increase. So the 60% must be for the federally defined primary care codes, not the codes Oregon considers primary care.

How to attest

We bill both DMAP and a health plan. How should we attest?

If you bill both DMAP and a plan, please attest with DMAP and we will share your attestation information with the plan. If you bill a plan but do not bill DMAP, then you must attest with the plan.

Must the provider submit the attestation or can an administrative person do the attestation for all the providers in the practice? What should the contact information be for these submissions?

Practitioners can designate someone in their office to do the attestation form for them. Make sure the attestation is completed to include the provider's identifying information and truthful attestation statements, and it will not be a problem.

It is OK to submit the phone number and e-mail address of the person completing the form on the practitioner's behalf instead of the practitioner's phone number or e-mail address.

We submit all our claims under our clinic's DMAP Provider ID. Can we use that on the form when we enter attestations for our providers?

No. We can't make a clinic eligible, so the clinic ID is not sufficient. The eligibility is at the practitioner level, so we need the practitioner's information. You already report your practitioners as rendering providers on your claims to DMAP, so you would use the DMAP Provider IDs that you enter for your rendering providers.

We have some new primary care providers starting under new a Tax ID on Mar. 1, 2013. Should we use their new Tax ID or their current Tax ID?*

When you submit your attestation, you enter your Medicaid ID and NPI so that we can match the attestation with the provider record in our system. When attesting for one of your rendering providers, please use the Tax ID associated with your provider's current Medicaid ID and NPI.

If you are enrolling new providers in your practice, for whom you also want to submit attestations, use the new Tax ID on your enrollment requests. If you send it now, we can get it into the system sooner. If you need to update Tax ID information in any existing provider records, please let us know as soon as possible (contact Provider Enrollment at provider.enrollment@state.or.us or 800-422-5047 with questions).

For clinics who bill DMAP, what is the easiest way to find the IDs for their providers?*

You can find the rendering provider IDs for your practitioners on your paper remittance advice (RA) from DMAP. We mail you a paper RA whenever you bill DMAP. For more information, see our [How to read the paper RA](#) guide (look under "Medical and dental – Paid examples").

You may also call DMAP Provider Services at 800-336-6016 for help reading the RA. You may also e-mail dmap.providerservices@state.or.us a list of providers and they will get back to you with the information.

How will providers know whether they qualify?

If you accurately completed all information on [the attestation form](#) and did not receive any "no" messages generated by the survey software, and you clicked the "Finish" button to submit it, you will qualify. (If you are a nurse practitioner or physician's assistant, your supervising physician must also qualify in order for you to be qualified.)

In early April, we will review all attestations received by Mar. 31, 2013 to verify whether they qualify for the rate increase. If we have questions about your attestation or do not feel you qualify for the increase based on the information we received, we will contact you.

How the rate will apply

Once a provider completes the attestation form, how soon will payments increase? Will you automatically go back and reprocess previously paid claims for the additional payment?

To be paid the increased rate retroactive to Jan. 1, 2013, providers must have completed [their self-attestation](#) by March 31, 2013. If a provider self-attests sometime in April-May-June 2013, then they will receive the increased rate retroactive to April 1, and so on.

We plan to begin the reimbursement process sometime after May 15. CMS needs to approve our Medicaid State Plan Amendment before we can actually start paying the increased rate.

Once we receive CMS approval, we will make automatic retroactive adjustments to your claims back to the beginning of the quarter in which you attested (if you have attested by April 30). For those attesting after April 30, if you do not hold your claims until you qualify, then you will need to adjust previously-submitted claims.

You will only be able to adjust claims for dates of service on or after the 1st day of the calendar quarter in which you self-attested.

Does the PA or NP have to bill under the supervising physician's Provider ID (not their own ID) to receive the increased rate?*

Continue to bill as you do today. Once the PA or NP [submits their attestation](#), we will update the PA/NP provider record so that services billed under the PA/NP number (as either billing or rendering) will pay at the increased rate.

Did Oregon rules apply earlier than CMS rules and if so, can we retro back to that effective date?

No. Oregon primary care rates were implemented August 2011, but they are unrelated to the CMS rule and the federal primary care increase. The CMS rule specifically applies to calendar years 2013 and 2014 only. We will only be able to pay the increased rate for services rendered on or after Jan. 1, 2013, when the federal provision became effective.

Is there is a difference in payment for multiple vaccinations given the same day under the Vaccines for Children (VFC) program?

Regardless of the National Correct Coding Initiative edits related to administration of vaccines, DMAP will pay multiple administration fees provided on the same day. Bill using the appropriate method for adult or children vaccines as outlined in Oregon Administrative Rule 410-130-0255.

Information for health plans (MCOs and CCOs)

Can you define "Panel" as in "Panel Provider"? For the CCOs, is that a provider who has a contract with us?

Yes. However, any provider who has self-attested would be paid the increased rate, even if the provider isn't contracted with you.

How will DMAP make the ACA-qualified provider data available to the plans?

We will collect the information from the [online attestation form](#) and include it in the weekly provider file to the plans.

Are health plans contracting with DMAP required to pay the increased rate to FQHC's or RHC's?

No. We have received clarification from CMS that CCO's and MCO's are not required to pay the increase to FQHC's or RHC's.

Can you clarify the attestation process? If a provider would like retroactive reimbursement he has to go through the attestation process?

Yes. Providers who attest will get reimbursed the enhanced rate back to the start of the quarter they attested in.

For providers who bill a plan, but not DMAP, the plan needs to establish a process to accept and review attestations, and apply the increased rate accordingly.

Is it correct that if a provider is on current Medicare Physician Fee Schedule (MPFS) rates that there is no change?*

If your rates to providers are equal to or better than DMAP's fee-for-service (FFS) rates for the increase, you would not need to make any changes to your rates. DMAP's rates for the federal primary care increase are approximately 106% of the 2013 MPFS when using the 2009 conversion factor of \$36.0666.

Can you clarify the use of the 2009 conversion factor of \$36.0666 or trended 2009 conversion factor of \$39.87?

The rates that were developed for 2009 were part of the 2009-2011 per capita costs, which used 2005- 2007 data. The 2006 conversion factor was \$37.90.

In the 2009 rates, we used \$39.87, which was \$37. 90 trended to 2009. The actual conversion factor in 2009 is \$36.06666.

When calculating how much of the rate will qualify for federal match, states must establish a basis for 2009. For FFS, it would be our 2009 conversion factor. For managed care, it would be the assumptions that were built into the primary care portion of the rates for 2009.

Then the rule provides for 100 percent federal match for the difference between that 2009 base and 2013 Medicare rates.

In addition to the calculation for capitated rates, will there be any guidance on blended FFS/capitated rate? (For example, a Per Member Per Month of \$10 plus a FFS payment of a lower rate than the standard rate.)*

For providers paid some capitation, who are also paid on a fee schedule for services that are out of capitation, you will need to demonstrate that the total payments to these providers reflect a fee schedule that is equal to, or better than, DMAP's FFS rates as described above.

This means that you will need to adjust your fee schedule for eligible primary care codes, and adjust your actuarial calculation to show that the codes in your capitated agreement have been adjusted to account for the federal primary care increase.

You may also need to state how your blended rate was calculated for payment.

If providers without DMAP IDs submit attestation paperwork to us, do they need to be enrolled with specialty code 328?

No, specialty code 328 is only required for providers who are DMAP fee for service providers. However, if you have providers without DMAP IDs who currently render services to OHP members, please enroll them with DMAP as encounter only providers. Plans will need to maintain their own lists of providers qualifying for the primary care increase who are not DMAP fee for service providers.

How will we know the effective date and the end date of provider qualification for the increase?

The effective date and end date are now shown in the provider file.

Will DMAP be processing provider attestations on an ongoing basis and will these changes be reflected in the DMAP provider file each week, or will DMAP process applications in batches (as they've done for this first quarter of the program)?

We will process the first applications in batches. However, after the providers who have attested by April 30 have been processed, we will begin processing applications each week or two. In either case, the provider file each week will reflect the most current status for each provider. The provider file can be sorted or filtered on the provider specialty to show the providers with specialty 328.

Would Plans need to have providers attest in order to receive the new Vaccine for Children rate of \$21.96?

CMS only requires Plans to raise the VFC rate for VFC providers who qualify for the federal primary care rate increase. Plans have the option of applying the new rate to all VFC providers, like DMAP; however, the capitation rates will only cover the rate increase that CMS requires.

This means that to receive the new VFC rate from Plans, contracted VFC providers:

- Need to attest with each Plan that chooses to only apply the rate to federally qualified primary care providers; and
- Do not need to attest with Plans that choose to apply the new VFC rate to all VFC providers (because primary care qualifications would not apply).

DMAP is applying the VFC rate increase to all VFC fee for service providers, regardless of whether they have attested for the primary care rate increase.