MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-66

Distribution: Practitioners, Hospitals, Medicaid Health Plans

Issued: December 1, 2012

Subject: Physician Primary Care Rate Increase

Effective: January 1, 2013

Programs Affected: Medicaid, Adult Benefits Waiver, *Plan First*

The Michigan Department of Community Health (MDCH) is implementing a provision of the Affordable Care Act (ACA), as included in section 1202 of the Health Care and Education Reconciliation Act of 2010, which provides increased payments for certain Medicaid primary care services. Under these regulatory provisions, certain physicians who provide eligible primary care services will be paid the Medicare rates in effect in calendar years (CY) 2013 and 2014 instead of the current state-established Medicaid rates.

For dates of service on and after January 1, 2013 and through December 31, 2014, MDCH will apply an increased payment rate to enrolled practitioners for primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The increase will apply to a specific set of services and procedures that the Centers for Medicare and Medicaid Services (CMS) has designated as "primary care services." Requirements related to the increased payments will apply to services reimbursed by Medicaid fee-for-service and Medicaid Health Plans (MHPs).

PROVIDER ELIGIBILITY

Physicians with specialty designations of family medicine, general internal medicine, and pediatric medicine qualify as primary care providers for purposes of increased payment. Services provided by all subspecialists related to these three designated specialty categories recognized by the American Board of Medical Specialties, American Osteopathic Association, and the American Board of Physician Specialists will qualify for the higher payment for primary care services.

Identification of Eligible Providers

Before enhanced payments are made, MDCH will verify that a physician meets the regulation's eligibility criteria which are identified as being either board certified in an eligible specialty or by conducting a thorough review of the physician's practice characteristics.

- Board Certification: A primary care physician who has self-attested by designating their primary specialty in their Community Health Automated Medicaid Processing System (CHAMPS) enrollment file as one of the three eligible specialties and has provided applicable Board certification information will be validated by MDCH prior to any enhanced payment.

- Review of practice characteristics: For non-board-certified physicians, Medicaid will review an enrolled provider's billing history for CY 2012. At least 60% of the physician's codes paid by Medicaid for all of CY 2012 must be for the evaluation and management (E/M) codes and vaccine administration codes specified in this regulation. This review of practice characteristics will be done by MDCH only on providers who have self-attested by designating in their CHAMPS enrollment file that their primary specialty is one of the three eligible specialties.

    - For a physician who newly enrolls as a Medicaid provider during either CY 2013 or CY 2014, who self-attests by designating that they are one of the three eligible specialties or subspecialties by their CHAMPS enrollment file, and is not Board certified, MDCH will review the physician's billing history at the end of the prior month in which enrollment occurs to confirm that 60% of the physician's codes paid by Medicaid were for primary care services eligible for payment under these provisions.

    - Re-determination of provider eligibility, when based upon the review of a provider's practice characteristics, will be required on an annual basis for this rate incentive.

- If a provider does not designate one of the three eligible primary specialties in their CHAMPS enrollment file, MDCH will not review a provider's board certification or practice characteristics to determine eligibility for this rate increase.

- Primary care services delivered at Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Local Health Departments (LHDs) are not eligible for these enhanced payments. According to the regulations, the rationale is that these services are reimbursed using a payment methodology designed to reimburse those providers at cost and are made on a facility basis, not specific to the physician's services.

- Non-physician practitioners, such as nurse practitioners (NPs) and physician assistants (PAs), who provide primary care services under the personal supervision of a physician who is one of the primary care specialties or subspecialty types designated in this regulation, will be eligible for the enhanced rate. Claims submitted by NPs and PAs must include their own NPI as the rendering provider and the NPI of their supervising/delegating physician. If the NP's or PA's supervising/delegating physician has not been identified as an eligible provider for the primary care rate incentive, as verified by CHAMPS enrollment, services performed by the NP or PA will not receive the enhanced rate.

- It is the intent of MDCH that a single standardized registry of qualified providers who are determined to be qualified for the enhanced rate will be established and maintained by the department and that this inventory of providers will be applicable to both FFS and managed care business.

ELIGIBLE PRIMARY CARE SERVICES

CMS has identified that Healthcare Common Procedure Coding System (HCPCS) E/M codes 99201 through 99499 are subject to the rate increase. In addition, vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474 are also eligible for the higher payment. MDCH will not be providing coverage of previously non-covered codes within this range as a result of this initiative.

ENHANCED RATES FOR PRIMARY CARE

For providers identified as eligible for the rate increase, payment will be made on the qualified procedure codes at the Medicare Physician Fee Schedule (MPFS) rates for CYs 2013 and 2014 or, if higher, the rate that will be applicable using the CY 2009 Medicare conversion factor. MDCH will apply the Medicare site of service (Facility vs. Non-Facility) differential and the Medicare geographic adjustment. MDCH will apply Medicare's two-tiered rates for locality 01 and locality 99 as defined by Medicare. Payment for the locality differential for services paid under this incentive will be determined by using the validated 9-digit ZIP code on the claim of where the service was performed.

MDCH will provide a separate fee schedule database for the two-year rate increase which will be located on the MDCH website under "Provider Specific Information" when the applicable rate factors have been finalized and published by CMS.

MDCH will apply the Medicare rates in effect at the beginning of CYs 2013 and 2014 and will apply those rates throughout the applicable calendar year without adjustments or updates. Medicare's mid-year fee schedule updates will not be applied.

When providing services to a beneficiary who is eligible for both Medicare and Medicaid, enhanced payments will be at the full Medicare rate for CY 2013 and 2014 instead of the customary Medicaid maximum allowable amount.

The Vaccines for Children (VFC) program does not permit payment for each vaccine/toxoid component administered. VFC providers receive one payment per vaccine regardless of the number of vaccine/toxoid components; therefore, the rate for HCPCS code 90461 will be $0.00 as it represents each additional vaccine/toxoid component administration procedure. VFC rates for administration will be reimbursed at the lesser of the 2013 and 2014 Medicare rates or the maximum regional VFC amount applicable in those years.

Application of Incentive Payments to CMS-1500 Claim Format

MDCH will not apply the primary care rate incentive to paper claim formats due to claims processing incompatibility and the informational requirements needed to execute the payment increases. Alternative claim submissions for eligible providers to receive their increased payment are available by submitting claims in the electronic equivalent HIPAA 837 professional format or by submitting claims through Direct Data Entry web submission. Another alternative is to submit a paper claim for a regular rate payment and then subsequently adjust the claim to include the required address ZIP code for the enhanced rate.

IMPLEMENTATION CONSIDERATIONS FOR MANAGED CARE PLANS

Pursuant to federal regulations, increased payments by MHPs for eligible primary care services to designated primary care providers is contingent upon CMS approval of the methodology for calculating the primary care rate differentials, certified rates, and any contract amendments required to implement these regulatory provisions. While it is anticipated that there may be some possible delays in payment by the MHPs to eligible providers due to this review process, it is emphasized that once the state receives CMS approval, any and all eligible MHP providers will receive the full amount of the enhanced payment effective for services provided on and after January 1, 2013 and CY 2014.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration