

HIV ENHANCED FEE FOR PHYSICIANS PROGRAM

(HIV-EFP)

PROGRAM DESCRIPTION & ENROLLMENT FORM

PROGRAM DESCRIPTION

The New York State Department of Health, AIDS Institute sponsors a program, which pays enhanced Medicaid fees for qualified primary care physicians and specialists who provide services to persons with Human Immunodeficiency Virus (HIV) disease. The Department invites interested physicians, who meet certain eligibility and practice requirements, to apply to participate in the HIV Enhanced Fee for Physicians Program (HIV-EFP).

To expand the network of HIV primary care providers, the NYSDOH is offering qualified, office-based physicians enhanced Medicaid reimbursement for HIV primary care services through the HIV-EFP program.

GENERAL PROGRAM REQUIREMENTS

1. Enrollment in the HIV-EFP is limited to physicians in private practice for services provided in their offices, or in other settings described in the Billing section that follows. Services provided by a physician under contract with a hospital or clinic may *NOT* be billed under this program. For further information, please refer to “*Situations Where Enrollment in the HIV-EFP Would Not be Appropriate.*”
2. HIV counseling and testing must be carried out in accordance with Article 27-F of the Public Health Law.
3. Physicians **MUST** be enrolled in the New York State Medical Assistance Program (Medicaid). Enrollment forms may be obtained by writing:

Computer Sciences Corporation
P.O. Box 4610
Rensselaer, NY 12144
or by calling (800) 343-9000 (select option 5)
or download enrollment forms from www.emedny.org

ELIGIBILITY AND PRACTICE REQUIREMENTS

The HIV-EFP eligibility and practice requirements for the primary care physicians and non-primary care specialist physician appear on subsequent pages of this program description.

REIMBURSEMENT

The physician participating in the HIV-EFP program will receive increased Medicaid fees for HIV visits provided to Medicaid recipients. These visits include HIV counseling and testing for recipients where HIV status is unknown and clinical care for those diagnosed with HIV.

The upstate reimbursement fees for office visits range from \$30 to \$36; the fees for downstate range from \$36 to \$42. The individual physician’s reimbursement for office visits will be a function of the distribution of his/her claims across the visit categories and the county in which services are rendered.

Physicians approved to participate in the HIV-EFP program are also eligible to apply to ADAP Plus Program. Under ADAP Plus, reimbursement is available for services provided to HIV infected

patients who are uninsured or underinsured and enrolled in ADAP Plus. For information regarding ADAP Plus please contact the Department of Health at 1-800-542-2437.

APPLICATION

An interested physician may apply to participate in the HIV-EFP program by completing the HIV-EFP Application and Agreement form. This form must be completed by every physician applying to participate in the HIV-EFP: the physician already enrolled as a Medicaid provider, the physician applying to enroll as a Medicaid provider and as an HIV-EFP participant, and the physician whose enrollment in Medicaid has lapsed but who wishes to re-enroll in Medicaid and participate in HIV-EFP.

Forms necessary to enroll in Medicaid may be obtained by written request to:

Computer Sciences Corporation
P.O. Box 4610
Rensselaer, NY 12144
or by calling (800) 343-9000 (select option 5)
or download enrollment forms from www.emedny.org

NOTIFICATION

A letter of decision regarding the Medicaid enrolled physician's application for HIV-EFP will be sent by NYSDOH to the physician's correspondence address as listed on the MMIS Provider File. If the application for Medicaid enrollment and HIV-EFP participation are made at the same time, the letter of decision regarding the Medicaid application will be sent first, followed at a later date by the letter of decision regarding HIV-EFP participation.

PHYSICIAN ELIGIBILITY AND PRACTICE REQUIREMENTS

A. PRIMARY CARE PHYSICIANS

To qualify, the primary care physician ***MUST*** meet the requirements described below:

1. The applicant must be enrolled in the New York State Medicaid Program. Please note that an application to enroll in Medicaid and the HIV-EFP can be submitted simultaneously.
2. The applicant must have active hospital admitting privileges in an appropriately accredited hospital to which he/she will admit patients under the HIV-EFP program.

The requirement for hospital admitting privileges may be waived for physicians who are unable to obtain such privileges for reasons outside their control. To be considered for a waiver of hospital admitting privileges, submit with this application (a) a description of the circumstances that merit consideration of the waiver; (b) evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege, and will monitor and provide continuity of care to the applicant's hospitalized patients; (c) a *curriculum vitae*; (d) proof of medical malpractice insurance; and (e) two letters of reference from physicians who can attest to the applicant's qualifications as a practicing physician.

When developing an agreement with another primary care physician, please note that only Medicaid enrolled physicians can bill for services provided to Medicaid recipients. In addition, only Medicaid enrolled physicians participating in the HIV-EFP can receive the enhanced fees for treating persons with HIV disease.

3. The applicant must be board certified (or board admissible for a period of no more than five years from completion of a post graduate training program) in internal medicine, pediatrics, family practice or OB/GYN. This requirement may be waived for general practitioners currently serving Medicaid patients in areas of the state where there are insufficient numbers of Medicaid enrolled qualified primary care physicians.
4. The applicant must provide 24 hour coverage of the practice. This can be accomplished by having an after-hours telephone number with an on-call physician, nurse practitioner or physician's assistant to respond to patients. This requirement can not be met by a recording referring patient to emergency rooms.
5. The applicant must coordinate medical care services, including at a minimum:
 - scheduling of elective hospital admissions;
 - assistance with emergency admissions;
 - management of and/or participation in hospital care and discharge planning;
 - scheduling of referral appointments with written referral as necessary and with request for follow-up report;
 - scheduling for necessary ancillary services such as lab, radiology, aerosolized pentamidine, infusion therapy, etc.;
 - arranging and obtaining prior authorization from the patient's local social service district for transportation services when necessary to insure access to health care; and,
 - maintaining a complete medical record.
6. The applicant must develop referral linkages with drug treatment programs and local AIDS community-based organizations.
7. The applicant must sign a written agreement with Medicaid, such agreement to be subject to cancellation with 30 days notice by either party.

B. **SPECIALISTS**

Due to the nature of the HIV disease, many persons infected with the virus may require consultation with and treatment by specialist physicians. To assure that access to specialty consultation is available and to assist primary care physicians with the management of their patients, specialists may enroll in the HIV-EFP program.

To qualify, a specialist physician **MUST**:

1. be enrolled in the New York State Medicaid Program;
2. have active hospital admitting privileges in an appropriately accredited hospital;

HIV COUNSELOR TRAINING

The Department of Health strongly recommends that all physicians providing HIV test counseling complete an HIV test counselor training program by the department in order to improve their HIV test counseling skills.

For information regarding HIV counselor training, contact the AIDS Institute Education and Training Section at (518) 474-3045. The information can also be found on the New York State Department of Health website: www.health.state.ny.us/nysdoh/hivaids/hivpartner/resourcedir.htm.

CONFIDENTIALITY OF PHYSICIAN PARTICIPANTS

The names of physicians who enroll in the HIV-EFP program will not be disclosed to any agency or individuals outside the AIDS Institute of the Department of Health without prior approval of the participating physician except as may be otherwise required by law. Enrolled physicians are under no obligation to accept additional HIV patients because of their participation in the program. However, if an enrolled physician wishes to be added to the referral lists of providers offering services to persons with HIV, the AIDS Institute will assist physicians in linking them with the appropriate community-based health and social service agencies which maintaining referral lists.

SITUATIONS WHERE ENROLLMENT IN THE HIV-EFP PROGRAM WOULD NOT BE APPROPRIATE

Physicians are paid by Medicaid for patient care in one of two manners: direct fee-for-service billing or through reimbursement to a hospital or clinic. The costs used to develop the Medicaid payment to a hospital or clinic may include physician salaries for administration, teaching and/or patient care. Medicaid should not be billed on a fee-for-service basis for patient care which is covered by a facility's rate since this would be duplicate billing.

If a hospital includes the physician's patient care salary in its Medicaid cost report, the salary covers care of the facility's patients in both the inpatient and outpatient setting. Medicaid should not be billed on a fee-for-service basis for hospital outpatient department patients even when they are seen in the inpatient setting.

If a physician receives any salary from a hospital or clinic, he/she must include with the HIV-EFP application, a letter from the Chief Executive Officer or Chief Financial Officer of the facility stating that the costs for his/her salary, as reported for the calculation of the facility's inpatient Medicare rate, do not include patient care.

AND

(b) a listing of the primary zip code areas that you serve.

9. I receive a salary from a hospital or clinic, Yes No

If yes, you MUST include with your HIV-EFP application a letter from the Chief Executive Officer or Chief Financial Officer of the facility stating that the costs of your salary, as reported for the calculation of the facility's inpatient or clinic Medicaid rate, DO NOT INCLUDE patient care.

10. I usually treat patients in my office(s):

A.

Street

City State Zip Code Telephone

B.

Street

City State Zip Code Telephone

11. The approximate number of HIV infected patients you have treated in the past five years:

SECTION C – HOSPITAL ADMITTING PRIVILEGE (Check as appropriate)

12. Yes, I have an active hospital admitting privilege. A copy of my hospital appointment letter which includes **admitting privileges is attached.**
- I do not have an active hospital admitting privilege, for circumstances that I believe merit consideration and have:
- (A) Attached a brief summary of the circumstances that support my request for waiver of the admitting privilege requirements.
- (B) Attached my *curriculum vitae* and proof of current medical malpractice insurance coverage and two letters of reference, each from a physician who can attest to my qualifications as a practicing physician.
- (C) Attached documentation of an agreement between myself and a primary care physician who: is licensed to practice in New York; is an approved Medicaid Provider; has an active hospital admitting privilege; and will monitor and provide continuity of care to my hospitalized patients. Please note that only Medicaid enrolled physicians can bill for services provided to Medicaid recipients. In addition, only Medicaid enrolled physicians participating in the HIV-EFP can receive the enhanced fees for treating persons with HIV disease.

NOTE: Please submit (A), (B) and (C) only if you do not have an active hospital admitting privilege.

SECTION D – ASSURANCE – UNDER THE HIV-EFP AGREEMENT

13. I recognize that I continue to be bounded by the rights, obligations, duties or interests accrued, incurred or conferred as a result of my enrollment in the New York State Medicaid Program.
14. As a qualified primary care physician, I assure the provision of comprehensive medical care services to Medicaid patients with HIV in accordance with generally accepted standards of medical practice and in accordance with the requirements of the HIV-EFP.

15. As a qualified primary care physician, I agree to provide medical care coordination which will include at a minimum, the scheduling of elective hospital admissions, management of and/or participation in hospital care and discharge planning; scheduling for necessary ancillary services; referrals for drug treatment and to community based AIDS service organizations; contact with the Medicaid patient's local department of social services when transportation services are necessary to assure access to health care; and the maintenance of a complete medical record to include but not be limited to notation of referrals and hospitalizations, and copies of test results and reports.
16. As a qualified primary care physician, I assure that I will maintain twenty-four hour telephone coverage which will include timely access to a practitioner qualified to respond to the Medicaid patient's health concerns. I recognize that this requirement can not be met by a recording referring patients to the emergency room.
17. As a qualified specialist, I assure that I will provide medical care coordination as necessary to these patients. Such medical care coordination should include at a minimum: the scheduling of elective hospital admissions, management of and/or participation in hospital care and discharge planning; periodic follow-up reports to the referring primary care provider regarding the plan for the outcomes of specialist services; scheduling for necessary ancillary services; and contact with the Medicaid patient's local department of social services when transportation services are necessary to assure access to health care.
18. I assure that patients with Medicaid will be free to choose from among qualified providers, any specialist to whom they will be referred. Please note that only Medicaid enrolled physicians can bill for services provided to Medicaid recipients. In addition, only Medicaid enrolled physicians participating in the HIV-EFP can receive the enhanced fees for treating persons with HIV disease.
19. I recognize that the State may determine new visit types and rates during the term of this agreement.
20. I recognize that the New York State Department of Health may cancel my participation in the HIV-EFP at any time, giving me not less than thirty (30) days written notice that on or after the date therein specified, my participation will end. I accept that cause for cancellation of my participation in the HIV-EFP program will include but not be limited to my failure to substantially comply with the terms of participation, including but not limited to failure to (a) permit access for patient record reviews or (b) accurately bill Medicaid under the reimbursement methodology.
21. I recognize that I may request cancellation of my participation in the HIV-EFP giving to the New York State Department of Health not less than thirty (30) days written notice. I assure that such cancellation will include a description of the basis for the request. I agree to continue to provide and/or arrange services for currently service patients up to the date of termination. I assure that I will assist patients to maintain continuity of care; to provide them with information to assist them in transferring their care and to make timely transfer of their records upon request.
22. I assure that I will abide to all policies, procedures and instructions provided by the State to implement and execute the HIV-EFP and will bill Medicaid in accordance with the reimbursement methodology established by the State.

Print Physician Name	Physician Signature	
Correspondence Address: _____		
Street		
City	State	Zip Code
Telephone Number	Date	
Email Address		

23. Do you have an Office/Claims Manager? Yes No If yes:

Office/Claim Manger Name	Telephone Number
Email Address	

MEDICAID PAYMENT TO PHYSICIANS FOR RAPID HIV TESTING

In concert with the federal Centers for Disease Control and Prevention, the New York State Department of Health, including the Medicaid program, supports the use of rapid, technologically simple devices, such as the OraQuick® rapid HIV test, in order to increase access to early HIV diagnosis and treatment and prevention services. To this end, effective for dates of service on or after June 1, 2004, **physicians enrolled in the HIV Enhanced Fee for Physicians (HIV/EFP) Program** will be eligible for Medicaid reimbursement for HIV antibody screening tests that he or she performs, personally or through practice employees, as an adjunct to the treatment of their patients.

Physicians performing HIV screens should use procedure code 86701, HIV-1 antibody, which has a maximum reimbursable fee of \$12.27, up to a maximum of one test per six month period per patient. Physicians that would like to enroll in the HIV/EFP Program should contact:

John Schnurr
HIV Ambulatory Care Administrator
New York State Department of Health
AIDS Institute
Room 459 Corning Tower
Albany, NY 12237
Phone: (518) 473-3786
Fax: (518) 473-8905
E-Mail: jjs09@health.state.ny.us

In order for a physician to be reimbursed for HIV tests, his or her physician office laboratory must be registered with Clinical Laboratory Improvement Amendments (CLIA), the federal laboratory oversight program, must hold certification appropriate for CLIA categorization of the test device being used and must be registered with Medicaid as a Physician Office Laboratory (POL). To date, the OraQuick® rapid HIV test is the only HIV test device categorized as waived; the OraQuick® device requires minimally a CLIA certificate of waiver, but may be performed under any level of certification.

Physicians may apply for a CLIA certificate by contacting the Physician Office Laboratory Evaluation Program at (518) 485-5352 for an application form. The application is also posted on the Centers for Medicare and Medicaid Services' website: <http://www.cms.hhs.gov/clia>. Select the option "How to Apply for a CLIA Certificate: Form CMS-116." A completed application must be submitted to the address of the local State agency for the state in which you will conduct testing. Physicians conducting testing in New York State should send their completed CMS-116 form to:

NYSDOH
Wadsworth Center
Physician Office Laboratory Evaluation Program
P. O. Box 509
Albany, NY 12201-0509

Physicians that already hold a CLIA certificate but are not enrolled with Medicaid as a POL must fill out the POL-CLIA information form below. A completed enrollment form must be submitted to the address listed at the top of the completed form.

If you require additional information related to Medicaid coverage for HIV tests, please contact the Bureau of Policy Development and Agency Relations staff at (518) 473-2160.

**MAIL TO: Computer Sciences Corporation
P.O. Box 4610
Rensselaer, NY 12144**

PHYSICIAN OFFICE LABORATORY - CLIA INFORMATION

INSTRUCTIONS:

1. Please print all required information.
2. A **SEPARATE** form must be submitted for **EACH** eligible physician in a group. If a physician works at multiple physician office laboratory sites, a **SEPARATE** form must be submitted for **EACH** site.
3. Attach a copy of the most recently issued valid Clinical Laboratory Improvement Amendments (CLIA) certificate from your site. If your physician office laboratory does not currently have a CLIA certificate, please contact the New York State Department of Health Physician Office Laboratory Evaluation Program at (518) 485-5352.
4. A letter of verification from the Centers for Medicare and Medicaid Services (CMS) or the New York State Department Physician Office Laboratory Evaluation Program is also acceptable evidence of CLIA certification. To obtain a letter from the New York State Department of Health Physician Office Laboratory Evaluation Program, please call (518) 485-5352.

New York State Medicaid Provider ID Number: _____

CLIA Certificate Number: _____

Physician License Number: _____

Physician Name: (LAST) _____ (FIRST) _____

Site Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number (___) _____

Please check the appropriate box for the type of CLIA Certificate held for this site: (check one):

Waiver PPMP Registration Compliance/Accreditation

(Provider Performing Microscopy
Procedures)

This item should be completed by legally organized group practice(s) only:

NYS Medicaid Provider ID Number for Group (if applicable): _____

Name of Group Practice: _____

Site Address: _____

City: _____ State: _____ Zip Code: _____

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