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QUALIFICATIONS

Q1. What is the Primary Care Rate Increase (PCRI)?

Effective for dates of service on and after January 1, 2013 through December 31, 2014, states are required by federal law to reimburse qualified providers at the rate that would be paid for the primary care service (if the service were covered) under Medicare.

See [Final Rule](#).

Q2. Which Medicaid providers qualify for payment?

A physician is eligible only if he/she **first** self-attests to practicing in the designated primary care specialties of Family Medicine, General Internal Medicine or Pediatric Medicine and **also to either being:**

Board certified in the designated specialties/subspecialties; **or** having a 60 percent **paid** claims history of both E&M codes and vaccine administration codes specified in the regulation.

The PCRI is not available for physicians, nurse practitioners or nurse midwives who are reimbursed through an FQHC, RHC, DTC or a facility's encounter, visit, or per diem rate or who are **not** practicing in one of the designated primary care specialties.

Refer to page 3 of the following CMS FAQ document, *FFS Set III*:

<http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html>

Q3. What does practicing as a designated primary care provider mean?

This is determined by the practice characteristics of the physician. For example, how the physician represents himself or herself in the community as a family, internal medicine or pediatric practitioner, as evidenced by medical directory listings, billings to other insurers, advertisements, etc.

Q4. Are subspecialists eligible for higher payment?

Subspecialists that may qualify for higher payment are those recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS) or American Osteopathic Association (AOA). See page 2 of *New York State Medicaid Fee For Service and Managed Care Primary Care Rate Increase Attestation* form for list of specific specialties. The NYS Attestation form is available at:

https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/490302_Increased_Primary_Care_Rate_Attestation.pdf

Also refer to page 2 of the CMS FAQ document, *Increased Medicaid Payments for PCPs* available at:

<http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html>

Q5. Does the 60 percent threshold include both E&M codes and vaccine administration codes?

Yes. The 60 percent threshold can be met by any combination of eligible E&M and vaccine administration codes.

Q6. Can non physician practitioners such as nurse practitioners and nurse midwives receive the higher payment?

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/she is supervising. If this is not the case, the practitioner would be viewed as practicing independently and would not be eligible for the PCRI. Refer to Section D. of the [New York State PCRI Attestation form](#).

Q7. What are the PCRI eligibility requirements for nurse practitioners and nurse midwives?

The eligibility of services provided by non-physician practitioners is dependent on: 1) the Primary Care Rate Increase eligibility of the supervising physician and 2) whether or not the physician accepts professional responsibility for the services provided by the non-physician provider(s). Those nurse practitioners and nurse midwives listed on the attestation form as being under the supervision and professional responsibility of the PCRI qualified physician would qualify for the rate increase. Refer to Section D. (page 2) of the New York State PCRI Attestation form. The NYS Attestation form is available at: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/490302_Increased_Primary_Care_Rate_Attestation.pdf And also available at: <https://www.emedny.org/info/ProviderEnrollment/midwife/Option1.aspx> and <https://www.emedny.org/info/ProviderEnrollment/nursePract/Option1.aspx>

Q8. Do physicians practicing in clinics or hospitals qualify for higher payment?

The PCRI does not result in any changes in billing policy for professional services provided in these settings. Higher payment does not apply to primary care services that are reimbursed on the basis of an all-inclusive rate, such as FQHCs, RHCs and free standing DTCs (no separate physician billing allowed). Since physician services are not included in hospital inpatient or hospital outpatient clinic rates in NYS, these physician services **will** qualify for the higher payment.

Q9. Do nurse practitioners and nurse midwives practicing in clinics or hospitals qualify for higher payment?

The PCRI does not result in any changes in billing policy for professional services provided in these settings. Higher payment does not apply to primary care services that are reimbursed on the basis of an all-inclusive rate (no separate practitioner billing allowed). Since NP and NM services are included in all hospital and clinic rates, the higher payment does **not** apply.

Q10. Can I qualify if I am Board certified in non-designated primary care specialty?

Yes, there may be physicians with Board certification in a specialty not recognized for higher payment under the rule who actually practice as pediatricians, family practitioners or internists who would be eligible for higher payment. For example, an OB/GYN who no longer practices in that specialty but practices as a family practitioner could appropriately self-attest to being a primary care provider. Such a provider would need to qualify based on the 60 percent threshold and not Board certification.

Q11. Do I automatically qualify for the enhanced payment if I am Board certified in a designated primary care specialty?

No. There may be physicians with Board certification in one of the three eligible specialty areas *who do not actually practice in those areas*. They should not self-attest to being a primary care provider.

Q12. If Board certification is used to confirm a physician's self-attestation, must the physician's board status be current or is initial board certification sufficient?

The certification must be current. If it has lapsed but the physician still practices as an eligible specialist the self-attestation would need to be supported with a 60 percent paid claims history.

Q13. Would Out-Of-State (OOS) providers be required to self-attest using NY Medicaid protocol, rather than relying on the determination made by the home state's Medicaid program?

Yes. As with all Medicaid services, the state in which the beneficiary is determined eligible sets the payment rate and attestation protocol for services.

Q14. Are Physician Assistants (PA) eligible for the program?

Since NYS does not enroll Physician Assistants as billing providers, PA services are billed under the supervising physician's NPI. The primary care services provided by a PA, supervised by a qualified physician are eligible for the increased rate. PAs do not complete the Attestation Form.

Q15. Can a physician consider the PA's primary care services as part of his/her 60% threshold?

Since the PA cannot bill Medicaid directly and subsequently bills his/her services under the physician's NPI, the primary care services provided by the PA will be considered part of the physician's 60% threshold.

Q16. Do services provided to Medicaid beneficiaries with third party insurance count towards the 60% threshold?

If Medicaid paid as secondary on a claim from a qualified provider, the claim can be counted within the 60% paid claims history of E&M codes and vaccine administration codes specified within the regulation.

ATTESTATION

A1. What form must a physician use to self-attest and qualify for higher payment under this provision?

The *New York State Medicaid Fee For Service and Managed Care Primary Care Rate Increase Attestation* form is available at:

https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/490302_Increased_Primary_Care_Rate_Attestation.pdf

Follow the instructions on page 2 of the Attestation form. Mail the completed form to the address listed at the top of page 1 of the Attestation form.

A2. The State or Managed Care plan already has my Board certification. Why do I have to attest to this again?

Board certification alone does not qualify a physician for the PCRI. The final rule requires that physicians first self-attest to practicing in the designated primary care specialties of Family Medicine, General internal Medicine or Pediatric Medicine, supported by either Board certification or an appropriate claims history. It is important that documentation exist that the physician himself or herself supplied a proper attestation. States cannot pay a physician without evidence of self-attestation.

A3. With respect to self-attestation, if a provider only meets the 60 percent threshold or only meets the Board certification, would the provider only have to attest to that one component to be eligible or is it necessary to meet both components?

Once the physician first self-attests to practicing in a designated primary care specialty they then have to attest to meeting **either** the Board specialty **or** 60% component.

A4. Do any forms need to be mailed in with the attestation?

No, only the completed Attestation form is mailed.

A5. How long does it take to get the letter from FFS after submitting attestation form?

Correctly completed attestations are normally processed within 30 days.

A6. Can a provider who is not enrolled in NYS Medicaid submit their attestation when they send in their enrollment application?

Yes, the PCRI Attestation and new enrollment request can be submitted and processed at the same time.

A7. If a provider works in more than one practice do they have to fill out the attestation more than once?

No. The attestation and eligibility are physician-specific. If a physician provides services in more than one practice, s/he need only complete the process of attestation once in order to receive higher payment for all eligible services s/he provides.

A8. Can attestation be done by a new physician?

A new physician can attest to being eligible if s/he is practicing in the designated primary care specialties of Family Medicine, General Internal Medicine or Pediatric Medicine and also either being currently Board certified in a designated specialty or subspecialty or has 60% paid Medicaid claims history **for the prior month**.

A9. Will NY Medicaid require another attestation in 2014?

No, only the initial attestation is required.

A10. I am a physician and I want to withdraw my qualification from the Primary Care Rate Increase program, what form do I use to withdraw my attestation?

You can submit the [PCRI Change/Update Attestation and Qualification](#) form. If your original attestation also qualified Nurse Practitioner(s)/Nurse Midwives, they will be withdrawn from the program. They may re-attest under another supervising physician.

A11. I missed the August 1, 2013 attestation deadline for January 1, 2013. How do I retroactively re-attest and change my qualifying effective date for the Primary Care Rate Increase program?

You must submit the [PCRI Change/Update Attestation and Qualification](#) form to change your PCRI effective date. The effective date must be between January 1, 2013 and December 31, 2014. Submit the form as soon as possible but no later than December 31, 2014. If the original attestation included Nurse Practitioners/Nurse Midwives, they also need to sign the form. The effective date they provide must be within their supervising physician's qualification period.

A12. How can I find out what was my original qualifying effective date for the Primary Care Rate Increase?

If you don't know your effective date, check the [PCRI website](#). The *Physician's List* spreadsheet includes the effective date of each physician, labeled as "PCRI Begin Date".

FEE FOR SERVICE

F1. How will the providers know which primary care services will be paid at the higher rate?

The regulation at 42 CFR 447.000(c)(1) and (2) specifies Evaluation and Management codes 99201 through 99499 and vaccine administration codes 90460, 90471, 90472, 90473, or their successor codes.

See following links for the latest Update on Vaccine Administration:

https://www.emedny.org/ProviderManuals/communications/H-052-10881_att1_Change_In_Billing_for_Vaccine_Administration_12-20.pdf and PCRI Fee Schedule <https://www.emedny.org/ProviderManuals/Physician/index.aspx>

F2. When will states begin making higher payment for Evaluation and Management services reimbursed fee for service?

New York began making the higher payments in fee for service within payment cycle 1872 (July 4, 2013).

F3. What can providers expect will be the schedule of PCRI payment prospectively?

The PCRI will be applied on a claim by claim basis through the normal eMedNY claims processing.

F4. In order to receive PCRI payments retroactive to January 1, 2013, by what date must the attestation form be submitted?

Submit the form as soon as possible. It must be postmarked by January 31, 2015 to qualify. The effective date on the form must be between January 1, 2013 and December 31, 2014. eMedNY will retroactively re-process your applicable claims.

F5. How will CMS and the State ensure that only eligible providers receive the higher rate?

Annually, the State must conduct a review of a statistically valid sample of physicians that have self-attested to either Board certification or a supporting claims/service history. Physicians must keep all information necessary to support an audit trail for services reimbursed at the higher rate.

F6. Is a state required to cover all of the primary care service billing codes specified in the regulation and then reimburse all qualified providers at the Medicare rate in CYs 2013 and 2014?

A state is *not* required to cover all of the primary care service billing codes if it did not previously do so. Rather, to the extent that it reimburses physicians using any of the billing codes specified in the final rule, the state must pay at the Medicare rate in CYs 2013 and 2014.

F7. Does higher payment apply to CHIP?

The primary care provider rate increase does apply to CHIP Medicaid expansion programs. In New York, the CHIP Medicaid expansion population is identified as Medicaid beneficiaries. Qualified physicians who render the primary care services and vaccine administration services specified in the regulation will receive the benefit of higher payment for services provided to these Medicaid beneficiaries. The higher payment does not apply to primary care services for beneficiaries enrolled in Child Health Plus, the separate (stand-alone) CHIP program in New York.

F8. What was State Plan Amendment (SPA) approval date?

The approval date was May 30, 2013. See [SPA](#).

F9. Will a copy of the PCRI presentation be available after the webinar?

The PCRI presentation is available at:

<https://www.emedny.org/info/ProviderEnrollment/physician/Option1.aspx>

F10. Will Medicaid pay the full 20% Medicare residual on dual eligible claims?

In CYs 2013 and 2014, the Medicaid rate for primary care services by the specified physicians will equal the Medicare rate. As a result, eligible physicians should receive payment up to the full Medicare rate for primary care services. When the Medicaid fee is equal to or higher than what Medicare pays for a Part B service, the Medicaid program will pay the full coinsurance amount.

F11. Is this payment subject to HCRA surcharge?

No, physicians are not subject to the HCRA surcharge.

F12. Will you publish the PCRI Fee schedule?

The PCRI Fee Schedule is available at:

<https://www.emedny.org/ProviderManuals/Physician/index.aspx>

F13. We have attested and have specialty code 31. Do we have to change the way we do our billing?

No, how you submit your claims and receive your payments will not change.

F14. What will the payment look like on the remittance?

Qualified providers will see an increase in the reimbursement on the eligible codes. There will no change in the remittance appearance.

F15. How are retroactive payments going to be made?

The retroactive reimbursement processing will start in September, 2013. Notification of the process will be provided via the eMedNY list serve.

F16. Will the PCRI for practitioner services that are office-based (POS code 11) be subject to the 2% ATB reduction?

All practitioner claims with Place of Service (POS) code 11 are exempt from the 2% ATB reduction.

F17. I've retroactively re-attested. Do the timely billing rules apply?

Yes, your claims for primary care services continue to be subject to the [timely billing rules](#). Providers should continue to bill claims on a timely basis. Original claims submitted within 90 days of the date of service and those with valid delay reasons, will be reprocessed on a quarterly basis by eMedNY as valid adjusted claims for you. Also see Questions F4 and A11.

MANAGED CARE

M1. If a physician renders services in both the managed care and fee for service environments, must he or she self-attest to eligibility twice?

No. The attestation and eligibility are physician-specific. If a physician provides services both in a fee for service and managed care environment, s/he need only complete the process of attestation once in order to receive higher payment for all eligible services s/he provides. [New York State PCRI Attestation form](#).

M2. Are eligible E&M and vaccination codes that are covered by managed care health plans but not under the Medicaid State plan eligible for reimbursement at the enhanced Medicare rate?

No. The only codes that are eligible for reimbursement at the Medicare rate as specified under the final rule are those eligible codes that are identified under the Medicaid State Plan. Additional E&M or vaccination administration codes that are being "covered" by a health plan but that are not identified in the state plan cannot be reflected in the rates.

M3. Are MCOs permitted to include amounts sufficient to account for the payment differential on expected utilization while still holding the sub-capitated primary care physicians at risk for some level of increase in utilization due to the higher rates? Or

must MCOs remove the risk to primary care physicians for utilization to ensure that these physicians receive the increased amount for actual experience?

The purpose of section 1202 of the Affordable Care Act and the final rule is to ensure access to and utilization of beneficial primary care services. Towards that goal, eligible primary care physicians must receive the full benefit of the enhanced payment at the Medicare rate for eligible services rendered. If a Medicaid managed care health plan retains sub-capitation arrangements, the health plan would be obligated to provide additional payments to providers to ensure that every unit of primary care services provided is reimbursed at the Medicare rate.

Refer to page 2 of the CMS FAQ document, Managed Care Set II, available at:

<http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html>

M4. How are case management fees in Primary Care Case Management (PCCM) programs affected by this rule?

PCCM payments are not eligible for higher payment under this rule.

M5. Will Medicaid health plans be required to pay eligible providers the higher rate prior to receiving payment from the State for the higher rate?

While some plans may be able to pay the higher rate prior to receiving state funds, the final rule does not obligate a health plan to pay eligible providers the higher rate until they have been provided the funds to do so.

M6. When and how will providers be paid by the Managed Care Plans (MCO)?

Currently, the State is seeking approval from CMS on its payment methodology to reimburse Managed Care Organizations (MCOs). Once approved, the State will begin making payments to MCOs retroactive to January 1, 2013. MCOs will then be required to notify each provider of the specific methodology used to calculate the enhancement and expected timing of payments. MCOs may amend their provider contracts to reflect the enhanced payment arrangement or develop a separate process to inform providers of the enhanced reimbursement and the associated payment arrangements.

M7. Will retroactive provider payments by health plans - necessitated by the State's retroactive payment of the higher rates to health plans - be subject to timely claims filing requirements in 42 CFR 447.46?

Any retroactive payments made to providers in order to ensure that eligible providers receive the applicable Medicare rate for eligible services will not be considered claims subject to the requirements in 42 CFR 447.46, *Timely claims payment by MCOs*.

M8. Will the MCOs also issue a specialty code to qualified providers?

Providers should inquire with the contracted Managed Care Organization(s) regarding their protocol for obtaining the PCRI.

- M9. Can providers who are contracted under a capitation, qualify for the PCRI?**
The PCRI applies to all qualifying providers and procedures whether contracted under a capitated arrangement or fee schedule with a Managed Care Organization.
- M10. Does the state define how MCO ultimately pays the provider - i.e. can MCO pay providers via lump sum for a quarter?**
The State does not define how Managed Care Organizations must reimburse their providers. The State does, however, mandate that providers be paid at least quarterly once funds are received from the State.
- M11. Will the MCO's EOBs clearly indicate what these payments represent uniformly as currently we are getting incentive payments with many different acronyms and terminology?**
The State is currently working through the process for reimbursing Managed Care Organizations. This issue will be addressed in that process.
- M12. MCOs payments can differ significantly from other MCOs. Will this be true of payment of the PCRI?**
The State's payment methodology specific to Managed Care stipulates that all requested reimbursement to Managed Care Organizations must be paid out to providers.
- M13. Does the MCO have any responsibility to confirm provider eligibility beyond the provider listing mentioned?**
Managed Care Organizations may use the State's provider attestation list as a substitute to developing an internal provider qualification process.
- M14. If the MCO has a contract that pays according to a fee schedule that is not based on Medicare/Medicaid rates, is the MCO required to change the fee to match the Medicare rate?**
The PCRI regulation requires all eligible providers must be paid at 100% of the Medicare Fee Schedule for qualifying E&M and vaccine administration procedure codes.
- M15. What is the complaint process for a provider, who is under a capitation plan with a managed care plan, should the provider have a problem with PCRI payments?**
The State will require Managed Care Organizations to develop a process to respond to provider complaints or concerns regarding the PCRI initiative.

M16. Can MCOs request confirmation that the PCRI was passed on to individual physicians in a physician group or facility?

Yes, it is acceptable for Managed Care Organizations to request this confirmation.

M17. Is the Medicare sequestration applicable to the PCRI for Managed Care Plans?

Managed Care Organizations using the State's published Medicare Fee Schedule to calculate the enhancement due providers will not have to adjust for the sequestration in Medicare rates.

***For any additional clarification, please send your question(s) to: <mailto:pcri@health.state.ny.us>**