

**Patient Protection and Affordable Care Act (ACA) 1202 - Increased Payments for
Primary Care Physicians
Frequently Asked Questions**

Attestation

1. Is there a deadline by which providers must submit the ACA Self Attestation Form (SAF)?

Yes, the last day for submission of the SAF is December 31, 2014, and will cover the period from January 1, 2013, through December 31, 2014. However, providers will not be able to receive any payments until their SAF has been completed. The online form is available on the [ACA Increased Medicaid Payment for Primary Care Physicians](#) page.

2. Does a provider need to submit the SAF only once during the time period in which the increased payments are in effect, excluding a need to resubmit due to changes or updates to the original submission?

Yes, the provider needs to submit the SAF only once during the time period in which the increased payments are in effect.

3. Will the state notify the provider that her/his SAF has been received/approved/denied?

Providers are notified of the result via email shortly after the completion of the online SAF. If you do not receive a confirmation email, please contact the Medi-Cal Telephone Service Center at 1-800-541-5555.

4. Can the Child Health and Disability Prevention (CHDP) program population count towards the 60 percent Medi-Cal threshold?

Yes, costs for CHDP health assessments and immunizations rendered to full-scope Medi-Cal beneficiaries count toward the 60 percent Medi-Cal threshold.

5. Can all providers attest or do providers have to be active/certified with Medi-Cal?

A physician, as defined in 42 *Code of Federal Regulations*, Section 440.50, with a specialty designation of family medicine, general internal medicine, pediatric medicine or a subspecialty within one of the listed specialties on the self-attestation form may attest. Non-physician medical practitioners (NMPs) practicing under the direct supervision of an eligible physician are also eligible for the payment increase. Providers do not have to be enrolled or certified as Medi-Cal providers for purposes of managed care claiming. Although these providers are not required to be enrolled in the Medi-Cal program, their attestation is still required for payment.

6. Should plans consider DHCS' SAF listing of subspecialties as the final determination of which subspecialties would need attestations?

Yes. The physician specialties and subspecialties listed on the self-attestation form is a complete listing of those eligible and who would need to attest.

7. Since the SAF only allows for five entries, what is the process for providers who are contracted with more than five Managed Care Plans (MCPs)?

At present, the SAF allows up to five MCP contracts to be entered. If any providers contract with more than five MCPs, these providers must notify all the MCPs or programs that they did not list on their completed attestation form.

8. When will the MCPs receive instructions on how to download the list of providers that have attested and have been found to be qualified?

The instructions to download the qualified provider attestation listing can be found on the [ACA Increased Medicaid Payment for Primary Care Physicians](#). Users will need to establish a user identification and password, and execute a *Medi-Cal Point of Service (POS) Network/Internet Agreement* to log on to Transaction Services. The "Transaction Services" area of the Medi-Cal website is located here <http://www.medi-cal.ca.gov/Services.asp>. Transactions services are available every day of the week between 2 a.m. and midnight. Once all of the requirements have been met, users can access the [Login to Medi-Cal](#) page. For assistance or questions, please contact the Medi-Cal Telephone Service Center at 1-800-541-5555.

9. Can provider groups use an agent to attest on behalf of all of their eligible providers? Can the MCPs send the Department of Health Care Services (DHCS) data files from their groups rather than having the groups individually attest to each doctor's eligibility?

Yes, it is acceptable for someone that works in the physician(s) office to attest on behalf of the physician(s) as long as the individual attesting has sufficient information to ensure that the provider meets the eligibility requirements. DHCS is not allowing for alternate modes of attesting, as the attestation system does not have those functionalities. For information on obtaining attestation data files, see question number 8 above.

10. Will Certified Nurse Practitioners (CNP) be allowed to self-attest under their own National Provider Identifier (NPI)? CNPs provide services under their own NPI number, and if they cannot self-attest, MCPs will have no visibility of their eligibility status.

Yes, for managed care, CNPs can self-attest under their own provider number. Non-physician medical practitioners (NMPs), such as CNPs and physician assistants, practicing under the direct supervision of an eligible physician are eligible for the payment increase. To receive payment, attestation is required. NMPs should self-attest with their individual NPI to receive payment from their managed care plan.

However, to receive payment from state fee-for-service, NMPs must be disclosed individually during the attestation process by the supervising physician. The supervising physician must attest even when an NMP is the individual actually delivering the care.

11. MCPs must start making enhanced payments to eligible physicians as soon as they receive (A) increased capitation payments from the DHCS and (B) a reliable listing of eligible providers from DHCS. How will DHCS ensure that eligible physicians whose services are billed by clinics make it on this list?

The listing of eligible physicians provided by DHCS will be based on the provider attestations that are accepted through the application process. MCPs should place reliance on the list. It is the physicians' responsibility to attest and ensure that their information is properly maintained in the DHCS system. Before making any enhanced payments, MCPs should review the physicians' eligibility. Please see answers to questions 7 and 8 about access to provider self-attestation information.

Managed Care Compliance Plan (MCCP)

For guidance on the Managed Care Compliance Plan (MCCP), refer to [All Plan Letter 13-010](#). The APL contains a Compliance Plan Checklist that is intended to provide the general guidelines for the formulation of a MCCP.

12. Will DHCS review and approve MCCPs?

DHCS will review the MCCPs within 45 days of receipt and issue a determination letter as to whether the minimum elements are met as outlined in APL 13-010. If the minimum elements are not met, MCPs will be expected to address the deficiencies within 30 days of receiving the determination letter.

13. Does DHCS expect a sub-capitated provider/health plan's compliance plan to be part of the main MCCP of the contract holder?

No. However, MCPs are responsible for ensuring that subcontractors are passing the payment increase to eligible providers and should specify how in the main MCCP.

Contract

14. When will MCPs receive the change order and contract amendments?

MCPs received the change orders for the 2013 ACA Primary Care Enhancement in December 2013. Contract amendments for 2012–13 were submitted to County Organized Health Plans (COHS) in December 2013 for execution and submission to CMS for approval. Additionally, COHS contracts for 2013–14 will be submitted to CMS in late January 2014. Change orders and contract amendments for 2014 for the two-plan model and the geographic managed care model are expected to be completed in February 2014 for submission to CMS during that same month with a May 2014 approval date expected.

15. What contract requirements must MCPs have in place with the medical groups?

Contract requirements are between the MCPs and medical groups, and may differ among MCPs based on the payment arrangements that are in place pursuant to the terms of the contract. However, MCPs should ensure that eligible providers are paid appropriate amounts.

Rates

16. What is the payment process for providers who contract with MCPs? Does DHCS provide the money and are MCPs obligated to pass 100 percent to the providers?

DHCS will pay the MCPs through a monthly capitation process. MCPs will then be responsible for paying eligible providers the appropriate amounts. Payment processes are determined based on the provisions of the contract between the MCP and providers. The full amount of the increase must be passed on to eligible providers.

17. When will providers begin receiving the enhanced rate for new claims and when/how will the state pay providers for prior claims submitted on or after January 1, 2013?

For state fee-for-service, an interim fee-for-service payment was released with the November 4, 2013, check write. A reconciliation of that payment could occur as soon as early summer.

For managed care, payments for the retroactive period of January – December 2013 will be made with the January capitation payment. It is anticipated that rates for 2014 will be released in March 2014 with the funding beginning in May 2014.

18. Will DHCS be releasing any additional crosswalks for Child Health and Disability Prevention (CHDP), Vaccine Administration, and Emergency and Management codes?

Yes. These additional crosswalks provide both the Medi-Cal fee-for-service maximum allowable rates as well as comparable Medicare maximum allowable rates for procedures defined by Section 1202 of the Patient Protection and Affordable Care Act (ACA). The crosswalks are posted on the [ACA Increased Medicaid Payment for Primary Care Physicians](#) page of the Medi-Cal website.

19. If a payment code is showing up on the primary care physician rate list, but is showing up as non-covered in the Medi-Cal website, is it covered only for those providers that attest? For all other providers will it continue to be non-covered?

If the service indicated is not covered by Medicare on the Medi-Cal website, then the service is not eligible for the increase.

20. Are Health and Safety Code 1206 (d) clinics (clinics conducted, operated, or maintained as outpatient departments of hospitals) eligible to receive the primary care increase?

Physicians are eligible to receive the primary care increase, not the clinics. DHCS pays the MCPs; the MCPs must then pass the enhancement on to eligible providers.

21. Will increased reimbursement rates be included in the quarterly Medi-Cal fee schedule update?

The Medi-Cal fee schedule will remain the same and will not reflect the ACA enhanced payment rates. Providers who are ineligible for the PCP increases will continue to refer to the regular fee schedule and providers who are eligible for the PCP increase can refer to the ACA rate link to view what they may be paid per code. Please see question 18 for rate crosswalk information.

22. Do the ACA adjusted capitation rates include an administrative load to the MCPs to account for the administration of the ACA?

Yes, the capitation rates include an administrative load as a result of the ACA. MCPs can find the administrative enhancement on the rate sheets that were transmitted in October 2013.

23. What is the process providers should use to seek the enhanced rate for eligible services that were listed in claims that have already been paid by a MCP plan?

Providers should contact their contracted MCP to obtain the MCP's protocol to receive payments for qualified services.

24. For Medi-Cal local codes with multiple Current Procedural Terminology (CPT) crosswalks, if providers do not have modifiers nor patient data, how should providers price the differential?

DHCS is requiring providers to utilize the ACA local modifiers when submitting fee-for-service claims to the state. If claims are received without an eligible ACA local modifier, the ACA payment will default to the lowest national code.

25. Why is vaccine code 90718 not on the crosswalk?

Code 90718 was in denied status until it was terminated on September 1, 2013, and is not included in the vaccine crosswalk for this reason.

26. Since providers will need to submit the vaccination and administration fee separately, will Medi-Cal provide an updated fee schedule for the vaccination to remove the administration fee? How should MCPs handle the administration that is built into vaccine codes?

The Medi-Cal fee schedule for the vaccinations will not change and, as a result, will include the administrative fee. MCPs should determine the actual payment amount for those eligible Vaccine Administration codes and adjust the administrative component to bring them to the required 2013 and 2014 levels.

- 27. Will DHCS continue to keep the existing fee schedule for vaccinations for providers who do not qualify for the PCP increase or provide an administration fee schedule for the non-qualified providers?**

The fee schedule will not change as noted in question 21 of this document.

- 28. Are the Vaccines for Children Program (VFC) rate increase requirements separate from the requirements for the payment rate increase for PCP services? Are MCPs required to pay providers who administer vaccines under the VFC program at the increased rate regardless of whether they self-attest or not?**

VFC rate increase requirements are not separate from the requirements for the payment rate increase for PCP services; they are the same. An attestation is required.

Reconciliation

- 29. According to DHCS, the annual reconciliation process, which is to occur each July, will be based on utilization reports submitted by the MCPs. However, the All Plan Letter states that amounts owed to or from the MCPs as a result of the reconciliation will be validated against reported encounters and adjusted accordingly. How is that process going to work? Is DHCS going to take into consideration things like encounter lag-time?**

DHCS intends to release the details of the reconciliation process in mid-February 2014, and discuss with the plan partners. Encounter lag-times and other items related to the reconciliation process will be discussed at that time.

- 30. When will the template for the annual true-up be made available?**

The reconciliation template will be available February 2014, when DHCS releases the details of the reconciliation process.

- 31. What level of auditing will be required at the MCP and group level? Will MCPs have to tie the increase to a specific provider claim and be able to drill down to the provider level? Can MCPs accept the group's attestation of compliance with audit capabilities?**

DHCS will audit the total enhanced payments passed onto MCPs and determine if this total was passed onto the provider groups. As a result, MCPs are expected to maintain an audit trail and to provide the reasoning for any enhanced payments made to providers. It is the MCP's responsibility to determine if a group maintains the appropriate documentation for audit purposes prior to disbursing any enhanced funding.

32. What will the ad hoc data requests from DHCS look like? Can DHCS provide further clarification on the reconciliation template and process?

Draft documentation relating to the audit and reconciliation process will be released in February 2014. At that time, DHCS will engage in stakeholder discussions to finalize the documents and the process.

33. How long do MCPs have to pass on the retroactive portion of the rate increase?

MCPs have until June 30, 2014, to pass on the retroactive portion of the 2013 rate increase. MCPs will have until June 30, 2015, to pass on the 2014 rate. However, it is DHCS' expectation that MCPs promptly disburse the increases as soon as administratively possible prior to the dates noted for the respective years.

34. What are the recoupment requirements if the provider groups are overpaid? What about enrollment changes?

The Model 2 retrospective reconciliation (100 percent true-up of utilization) will take place between the MCPs and DHCS. Actual member months by Category of Aid/Rate Cell and County will be utilized, so enrollment changes will not impact results. With respect to potential overpayments between the MCP and its provider groups, information on related payment adjustments should be covered within the MCPs ACA 1202 compliance plan and in its contract with the provider group.

35. Are there any audit mechanisms or regulations anticipated to ensure that the IPAs do not lower their reimbursement to PCPs now that PCPs are getting a new source of revenue directly from the MCP?

DHCS will consider this dynamic when developing its audit and reconciliation plan and will be actively seeking stakeholder input in February 2014. In the interim, MCPs should determine if this type of activity is occurring regularly and make DHCS aware of it.

36. The MCP intends to provide applicable payments to capitated/delegated Independent Practice Associations (IPAs) and in turn require their certification. Please confirm this action complies with: Provide a MCP to certify 100 percent of increased payments are paid to eligible providers.

The process described is an essential element of the MCCP. However, MCPs and the respective IPAs should maintain documentation for audit purposes supporting the legitimacy of the enhanced payments.

37. Primary care providers at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are not eligible for this increased funding. How do we ensure that FQHCs or RHCs do not accidentally receive this bump? Will DHCS be communicating to MCPs that FQHCs and RHCs are excluded and that they should not enhance their reimbursement to this group?

Any providers who receive enhanced payments and who do not qualify will be required to return the payments to the disbursing party and the MCP. Non-qualifying payments will be detected through the audit and reconciliation process in a managed care environment. In the fee-for-service environment, edits are built into the payment system to protect against ineligible provider types from receiving the increase.

State Plan Amendment

38. When will the final State Plan Amendment (SPA) be released?

The SPA was approved on October 24, 2013. SPA 13-003 is available to download from the [2013 Approved State Plan Amendments \(SPA\)](#) page of the DHCS website.