

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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June 23, 2014

Mr. Lawrence Kissner, Commissioner  
Department for Medicaid Services  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001



Re: Federal Financial Participation for primary care services provided in Community Mental Health Centers (CMHCs)

Dear Mr. Kissner:

This letter is in response to your letter dated May 7, 2014, requesting guidance about federal financial participation (FFP) for primary care services provided in Community Mental Health Centers (CMHCs).

CMHCs are usually paid as clinics, using an encounter or visit rate. In such instances they are not eligible for enhanced payments authorized under Section 1202 of the Affordable Care Act (ACA). CMHCs must be paid for services they provide at the Medicaid physician fee schedule rates (as opposed to an encounter or visit rate) in order to be eligible to receive Section 1202 enhanced payments.

When CMHCs are reimbursed on the physician fee schedule, the individual physicians could be paid at the higher rates on the condition that all other eligibility requirements are met. In order to be eligible for higher payment:

- 1) Physicians must first self-attest to a covered specialty or subspecialty designation.
- 2) As part of that attestation they must specify that they either are Board certified in an eligible specialty or subspecialty and/or that 60 percent of their Medicaid claims for the prior year were for the evaluation and management codes specified in the regulation. It is quite possible that physicians could qualify on the basis of both Board certification and claims history.
- 3) Only individuals providing services under the direct supervision of a physician are eligible, assuming the physician himself meets all Section 1202 requirements. This means that the physician accepts legal and professional liability for services provided

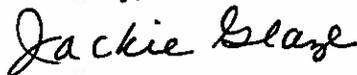
by those individuals supervised. Physician assistants and nurse practitioners are never eligible on their own.

- 4) If the physician is qualifying on the basis of 60 percent of claims, they must be their own individual claims (as well as those of the individuals for whom they accept professional responsibility), not the claims associated with the CMHC as a whole.

CMS has posted six sets of questions and answers on the requirements related to the enhanced Medicaid payments for primary care services which can be found on the CMS website at <http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html>. In addition, I've attached a copy of the questions and answers.

If you have additional questions, please contact, Davida Kimble, Manager, Financial Management Branch 1 at (404) 562-7496.

Sincerely,



Jackie Glaze

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

Enclosure

**Qs &As on the Increased Medicaid Payment for Primary Care  
CMS 2370-F**

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

Effective for dates of service on and after January 1, 2013 through December 31, 2014, states are required by law to reimburse qualified providers at the rate that would be paid for the service (if the service were covered) under Medicare. Most states and the District of Columbia will need to submit a Medicaid state plan amendment (SPA) to increase Medicaid rates up to this level. CMS has issued a SPA preprint for the purpose of expediting review and approval of the primary care payment increase.

For dates of service starting January 1, 2013 qualified providers are entitled to receive the higher payment in accordance with the approved Medicaid state plan amendment. States may not have attestation procedures or higher fee schedule rates in place on January 1, 2013. In that event, providers will likely continue to be reimbursed the 2012 rates for a limited period of time. Once attestation procedures are in place and providers are identified as eligible for higher payment, the state will make one or more supplemental payments to ensure that providers receive payment for the difference between the amount paid and the Medicare rate. Qualified providers should receive the total due to them under the provision in a timely manner.

A state may draw federal financial participation for the higher payments only after the SPA methodology is approved.

**Which Medicaid providers qualify for payment?**

**Can physicians qualify solely on the basis of meeting the 60 percent claims threshold, irrespective of specialty designation?**

**Would a Board certified “general surgeon” qualify for higher payment if he or she actually practices as a general practitioner?**

The statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. Under the regulation, “general internal medicine” encompasses internal medicine and all subspecialties recognized by the ABMS, ABPS and AOA. In order to be eligible for higher payment :

- 1) Physicians must first self-attest to a covered specialty or subspecialty designation.

- 2) As part of that attestation they must specify that they either are Board certified in an eligible specialty or subspecialty and/or that 60 percent of their Medicaid claims for the prior year were for the E&M codes specified in the regulation. It is quite possible that physicians could qualify on the basis of both Board certification and claims history.

Only physicians who can legitimately self-attest to a specialty designation of (general) internal medicine, family medicine or pediatric medicine or a subspecialty within those specialties recognized by the American Board of Physician Specialties (ABPS), American Osteopathic Association (AOA) or American Board of Physician Specialties (ABPS) qualify.

It is possible that a physician might maintain a particular qualifying Board certification but might actually practice in a different field. A physician who maintains one of the eligible certificates, but actually practices in a non-eligible specialty should not self-attest to eligibility for higher payment. Similarly, a physician Board certified in a non-eligible specialty (for example, surgery or dermatology) who practices within the community as, for example, a family practitioner could self-attest to a specialty designation of family medicine, internal medicine or pediatric medicine and a supporting 60% claims history. In either case, should the validity of that physician's self-attestation be reviewed by the state as part of the annual statistical sample, the physician's payments would be at risk if the agency finds that the attestation was not accurate.

**The Affordable Care Act specifies increased payments for three primary care medical specialties: Family Medicine, General Internal Medicine and Pediatrics. The Final Rule interprets this language to include some subspecialties with a relation to the original three, but does not list the subspecialties. Please identify the subspecialists eligible for higher payment.**

Subspecialists that 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). For purposes of the rule, "General Internal Medicine" encompasses "Internal Medicine" and all recognized subspecialties. The websites of these organizations currently list the following subspecialty certifications within each specialty designation:

ABMS

Family Medicine – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine

Internal Medicine – Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Geriatric Medicine; Hematology; Hospice and Palliative Medicine; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Sleep Medicine; Sports Medicine; Transplant Hepatology.

Pediatrics – Adolescent Medicine; Child Abuse Pediatrics; Developmental-Behavioral

Pediatrics; Hospice and Palliative Medicine; Medical Toxicology; Neonatal-Perinatal Medicine; Neurodevelopmental Disabilities, Pediatric Cardiology; Pediatric Critical Care Medicine; Pediatric Emergency Medicine; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology, Pediatric Transplant Hepatology; Sleep Medicine; Sports Medicine.

### AOA

Family Physicians – No subspecialties

Internal Medicine – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Disease; Pulmonary Diseases; Nephrology; Oncology; Rheumatology.

Pediatrics – Adolescent and Young Adult Medicine, Neonatology, Pediatric Allergy/immunology, Pediatric Endocrinology, Pediatric Pulmonology.

### ABPS

The ABPS does not certify subspecialists. Therefore, eligible certifications are: American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine. There is no Board certification specific to Pediatrics.

**Is self-attestation required or may a state rely solely on information about Board certification gathered upon provider enrollment or data on a physician's MMIS claims history to determine eligibility for this payment?**

The rule requires that physicians first self-attest to an eligible specialty or subspecialty and then attest to either Board certification or an appropriate claims history. States cannot pay a physician without evidence of self-attestation.

**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.

**The American Board of Physician Specialties does not certify subspecialists. Which Board certifications would qualify a physician for higher payment?**

Physicians who are Board-certified by the ABPS in Internal Medicine, Family Practice, or Family Medicine Obstetrics would qualify for higher payment.

Physicians with a certification in Family Medicine Obstetrics are all certified first in family medicine with additional certification in obstetrics. They practice as family practitioners and are

therefore able to self-attest to a qualified specialty. This is not true of individuals certified in obstetrics by either the ABMS or AOA who do not qualify for higher payment.

**Can a physician self-attest to Board certification or a supporting claims history after January 1, 2013, when the primary care payment increase begins but expect higher payment back to the beginning of the year?**

States must have the appropriate self-attestations in hand before they can pay physicians at the higher rate. States can impose reasonable requirements regarding “retroactive” self-attestations to facilitate program administration. For example, a state could limit retroactive payments to the beginning of the month or quarter in which the attestation is submitted. However, physicians must be made aware of the payment provision and of the requirements concerning self-attestation before January 1, 2013 through state provider bulletin or manual systems or other mechanisms.

**May a state automate its process for identifying qualified providers?**

Yes. A state may automate its process for identifying physicians that qualify for this payment provided the process is transparent and legally binding. A state may not rely on a physician’s taxonomy in place of self-attestation to Board certification or a supporting claims history.

At the end of CYs 2013 and 2014 the Medicaid agency must review a statistically valid sample of physicians who self-attested either to Board certification or a supporting claims history to determine the validity of the data.

**How will CMS ensure that only eligible providers receive the higher rate?**

The final rule requires physicians to self-attest to an eligible specialty designation and to further indicate whether they are Board certified in an eligible specialty or subspecialty or 60 percent of the services for which they bill are for eligible E&M or vaccine administration codes. Annually, states 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 and State Medicaid agencies must keep all information necessary to support an audit trail for services reimbursed at the higher rate.

**If the sampled data indicates the inclusion of non-qualified providers should repayment be based upon data for all physicians who received higher payment or only the sampled providers?**

CMS will require that the state repay erroneous payments found through the sampled pool of providers, and will not extrapolate data from the sample to the entire universe of physicians who received the higher primary care payment. States with high error rates should submit a plan for corrective action to reduce errors.

**Can mid-level/non physician practitioners such as nurse practitioners 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 is supervising. If this is not the case, the practitioner would be viewed as practicing independently and would not be eligible for higher payment.

**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.

**Do physicians practicing in FQHCS and RHCs qualify for higher payment?**

Higher payment does not apply to services provided under another Medicaid benefit category such as clinic or Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

**Will the new payment rate for each of the billing codes affected by this regulation be made publicly available?**

Yes. This information will be made available on Medicaid.gov. States will be asked to verify the payment amount in effect for each of the billing codes affected by the final rule as of July 1, 2009.

**Will CMS issue a preprint for the increased physician payment?**

Yes. CMS has provided a preprint for the reimbursement section of the Medicaid state plan that will describe payment for evaluation and management services and vaccine administration. The preprint is available on Medicaid.gov.

**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.

**Will a state receive 100 percent federal matching funds for new codes added to the fee schedule in CYs 2013 and 2014?**

A state may not add any of the eligible service codes solely for the purpose of obtaining enhanced federal matching funds. For example, a state may not eliminate a code currently in use and attempt to substitute it with another E&M code.

However, we recognize that a handful of codes have been added to the E&M code set since 2009. States which added those codes to their fee schedules will receive higher match for those services.

**The NPRM provided that states were required to pay the lesser of the provider's charges or the applicable Medicare rate. The final rule no longer specifies this. Can a state continue to pay at the lower of the two amounts?**

Under Medicare and Medicaid principles, payment is to be made at the lower of provider charges or the rate, which in this case is the applicable Medicare rate. This language was inadvertently omitted from the final rule. CMS is processing a technical correction to the regulatory text at 42 CFR 447.405 to restore this language.

**Does higher payment apply to CHIP?**

The primary care provider rate increase does apply to CHIP Medicaid expansions but not separate (stand-alone) CHIPs. 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 State will receive 100 percent federal matching funds for the difference between the rate in effect 7/1/09 and the rate in CYs 2013 and 2014. The remainder of the payment will be funded at the CHIP matching rate, through the CHIP allotment. Services provided under separate (stand-alone) CHIPs are not eligible for higher payment.

**The rule indicates that all limitations, conditions and policies that applied to the code prior to January 1, 2013 can be applied to the code after that date. If a state sets a reduced rate for a Level III emergency service (99283) if it is a triage service (based on criteria described in the state plan) can it continue to do so or must it pay 100 percent of the Medicare rate? If it can continue to reduce the rate, must it develop a "Medicare triage rate", or can it continue to use the Medicaid triage fee?**

This rule does not affect the state's ability to define and operate its coding system, and a state could distinguish claims submitted from those otherwise identified with code 99283. For those claims, the state should develop a rate that it believes Medicare would pay if Medicare made a similar distinction for emergency services limited to triage services, and would then pay that rate. For claims that were not limited to triage services, the state would pay based on the established Medicare rate for code 99283.

**What federal matching rate will apply for services for which a higher payment is made under this rule, if the services also qualify for a higher FMAP under the provisions of section 4106 of the Affordable Care Act?**

In qualifying states, certain United States Preventive Services Task Force (USPSTF) grade A or B preventive services and vaccine administration codes are eligible for a one percent FMAP increase under section 4106 of the Affordable Care Act (which amended sections 1902(a)(13) and 1905(b) of the Act). Some of these services may also qualify as a primary care services eligible for an increase in the payment rates under section 1202 of the Affordable Care Act. For these services the federal matching rate is 100 percent for the difference between the Medicaid rate as of July 1, 2009 and the payment made pursuant to section 1202 (the increase). The federal matching payment for the portion of the rate related to the July 1, 2009 base payment would be the regular FMAP rate, except that this rate would be increased by one percent if the provisions of section 4106 of the Affordable Care Act are applicable.

### **Primary Care Services and Vaccine Administration**

**How will States and 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, 90461, 90471, 90472, 90473, or their successor codes.

**What will the reimbursement rate be for those E&M codes that Medicare does not cover?**

The final rule provides that CMS will use develop reimbursement values based on the formula used to set Medicare rates. We will make this information available through Medicaid.gov.

**How will vaccine administration be paid for services vaccines provided under the Vaccines for Children (VFC) program?**

As specified at 42 CFR 447.405(2)(b) for vaccines provided under the Vaccines for Children Program (VFC) in CYs 2013 and 2014, a state must pay the lesser of: (1) the Regional Maximum Administration Fee; or, (2) the Medicare fee schedule rate in CY 2013 or 2014 (or, if higher, the rate using the 2009 conversion factor and the 2013 and 2014 RVUs) for code 90460.

This complies with the statutory requirements of the VFC program that limit payments to the VFC ceiling, which is the amount charged by the provider, and to one payment per vaccine administered regardless of the number of antigens in the vaccine. In 2013 and 2014, CMS expects that the regional VFC ceilings will be lower than the Medicare rates, which will result in a payment increase to providers.

**Qs &As on the Increased Medicaid Payment for Primary Care  
CMS 2370-F - MANAGED CARE**

**What federal match rate is available to the states for administrative costs incurred from implementation of this rule?**

The regular administrative federal match rate is applicable to administrative costs associated with implementation of this rule. Section 1905(dd) of the Social Security Act (the Act) authorizes increased FMAP only for eligible services provided by eligible providers pursuant to section 1902(a)(13)(C) of the Act.

**Primary Care Services under Managed Care Delivery Systems**

**The requirements under 42 CFR 438.804 specify that the states submit two methodologies to the Centers for Medicare & Medicaid Services (CMS) for review and approval to implement this rule. How does approval of these methodologies impact the approval process for managed care contracts and rate packages for 2013?**

Implementing regulations at 42 CFR 438.804 require states to submit to CMS a methodology for calculating the July 1, 2009, baseline rate for eligible primary care services and a methodology for calculating the rate differential eligible for 100 percent of Federal Financial Participation (FFP) by March 31, 2013. Further, 42 CFR 438.6 (c)(5)(vi) establishes Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) contract requirements to comply with this provision. It is CMS's expectation that as soon as practicable after the State submits the required methodologies in 42 CFR 438.804 and receives CMS approval, the State will:

1. submit revised actuarial certification documents reflecting the Medicare rate for eligible primary care services in their MCO, PIHP or PAHP capitation rates; and
2. submit amendment(s) to this contract to ensure compliance with 42 CFR 438.6 (c)(5)(vi).

After CMS approval of the revised contract and rates, the MCO, PIHP or PAHP must direct the full amount of the enhanced payment to the eligible provider to reflect the enhanced payment effective January 1, 2013. Federal financial participation (FFP) is available at a rate of 100 percent for the portion of capitation rates attributable to these enhanced payments; however, receipt of the enhanced FFP is contingent upon the state's successful completion of this process.

**Can managed care plans under contract with a state use their own definitions of primary care providers and services for purposes of complying with this rule?**

While we recognize that health plans may have unique definitions of primary care providers and services, the availability of the increased FMAP is limited to the scope of eligible primary care providers and primary care services as defined in statute and implemented by this rule.

**Are bonus payments and other incentive arrangements for health plans included in the methodology for determining the rate differential that is eligible for 100 percent FFP?**

We addressed the treatment of bonus payments and other incentive arrangements in terms of identifying the 2009 base rate in the final rule and take this opportunity to clarify that such arrangements are similarly excluded from the methodology for determining the rate differential.

**Is the relevant Medicare rate both the ‘floor’ and ‘ceiling’ for health plan payments to eligible providers for eligible services?**

The applicable Medicare rate does effectively become the ‘floor’ for payments to eligible providers for eligible services, but not the “ceiling.” Health plans may pay above that rate depending on their specific contractual arrangements with providers.

**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.

**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? If so, may States impose liquidated damages or other penalties on health plans for violating those requirements?**

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.

**When will CMS provide standardized contract language reflecting the requirements of this provision as mentioned during the All-State Call on November 8th?**

CMS will be working collaboratively with the National Association of Medicaid Directors (NAMD) to develop the contract elements necessary to reflect the requirements of this rule. In recognition of the State Medicaid Agency’s role in the contracting practice, CMS will describe the suggested content areas rather than issue standardized contractual language. These elements will be described in further detail in a future Q&A document.

**How will states with Medicaid managed care programs comply with the requirement to report provider participation levels specified in 42 CFR 447.400(d)(1)?**

At this time, CMS is not defining the form of information required under 42 CFR 447.400(d)(1), but we do suggest that states with Medicaid managed care programs conduct a baseline assessment of primary care access before the provision goes into effect. This baseline assessment will ensure that Congress, CMS, and researchers have comparative data to evaluate this provision.

**Qs &As on the Increased Medicaid Payment for Primary Care  
CMS 2370-F - MANAGED CARE (Set II)**

**May States delegate the self-attestation process to their contracted managed care plans?**

Yes. A state may elect to delegate the self-attestation process to its contracting health plans under the following circumstances:

1. Each managed care plan has signed documentation on file (provider contract or credentialing application) from the eligible provider attesting to the fact that he or she has a covered specialty or subspecialty designation. This addresses step 1 of the 2-step self-attestation process specified in the rule.
2. The managed care plan has verification of the provider's appropriate Board certification (as part of the credentialing and re-credentialing process). This addresses one option of the 2nd step in the self-attestation process.
3. Should Board certification in the eligible specialty not be able to be verified by the managed care plan, the eligible provider must provide a specific attestation to the managed care plan that 60 percent of their Medicaid claims for the prior year were for the HCPCS codes specified in the regulation. This addresses a second option for the 2nd step in the self-attestation process.
4. Such delegation is included in the contract amendment that is otherwise being filed to implement this provision.

**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.

**The final rule specified that states will need to recoup the enhanced payments made to non-eligible providers identified through the annual statistically valid sample. Must health plans follow the same procedure for non-eligible providers?**

States must require health plans to recoup erroneous payments found through the sampled pools of providers, and in a number of states, this sample will include both FFS and managed care providers.

**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.

**May states continue to use discounted reimbursement rates for out-of-state or out-of-network eligible primary care providers, which may be less than the Medicare rate, for CYs 2013 and 2014?**

CMS acknowledges the customary practice of reimbursing out-of-state or out-of-network providers at a base rate minus a defined percentage. As provided in an earlier Q&A, the applicable Medicare rate effectively becomes the 'floor' for payments to eligible providers for eligible services rendered in CYs 2013 and 2014. Health plans may pay above that rate but not below.

## Qs and As on the Increased Medicaid Payment for Primary Care

### CMS 2370-F (Set II)

**May providers self-attest through the use of a claims modifier? The state will issue a communication instructing providers that only those who are board-certified in a specified specialty/subspecialty or who meet the 60 percent threshold of appropriate claims history are eligible to receive the rate increase.**

**Can a state review providers whose claims meet the 60 percent threshold and assume that those providers would be automatically eligible?**

Each physician must self-attest to being a qualified provider. It is not appropriate for a state to rely on a modifier to a claim for the initial self-attestation. Under the final rule, states are not required to independently verify the eligibility of each and every physician who might qualify for higher payment. Therefore, it is important that documentation exist that the physician himself or herself supplied a proper attestation. That attestation has two parts. Physicians must attest to an appropriate specialty designation and *also* must further attest to whether that status is based on either being Board certified or to having the proper claims history. Once the signed self-attestation is in the hands of the Medicaid agency, claims may be identified for higher payment through the use of a modifier.

**If a physician presents a certificate from one of the defined boards, can the certificate be used as the legal document verifying the physician's certification or does the State have to verify with the board that the physician is certified of that the presented certificate is still active and valid?**

States may accept the certificate and need not verify. The Centers for Medicare & Medicaid Services (CMS) expects states to make physicians aware that they are responsible for providing accurate information.

**With respect to the use of board certification 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 claims history.

**Please clarify that if a state opts to pay out the rate increase in a lump sum payment, it must be done quarterly or more frequently and that the state plan preprint will make this clear.**

The final rule specifies that such payments must be made no less frequently than quarterly, as does the final preprint issued by CMS.

**CMS clarified in the final rule that, for out of state providers, the beneficiary's home state (e.g., state A) may defer to the determination of the physician's home state (e.g., state B) with respect to eligibility for higher payment. However, if states A and B receive different Medicare locality adjustments, which locality rate must be paid?**

As with all Medicaid services, the state in which the beneficiary is determined eligible (state A) sets the payment rate for services. Therefore, state A would be responsible for paying using the methodology it had chosen with respect to determining the appropriate Medicare rate and would not be required to pay the rate the physician would receive from state B.

**The final rule indicated that 100 percent Federal Financial Participation (FFP) is not available for stand-alone Children's Health Insurance Program (CHIP) plans. What criteria should be used to determine if a plan is a stand-alone CHIP plan? What agency will determine if a plan is a stand-alone CHIP plan?**

CMS approves CHIP programs as stand-alone or Medicaid expansions. Information on whether or not a particular state operates a stand-alone or expansion program is available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/Map-CHIP-Program-Designs-by-State-.pdf>

**FQHCs/RHCs which receive an encounter rate are excluded under the rule. Are FQHCs/RHCs who are paid provider fee-for-service included in the increase?**

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are required by law to be paid at least prospective payment system (PPS) for core primary care services. Physician services are core FQHC and RHC services and, therefore, should not be reimbursed on a fee-for-service basis.

**In our state, advanced practice nurses must have a collaborative practice agreement with a physician within 50 miles of their office. Under the collaborative practice agreement, a physician must review a certain percentage of the nurse's patient charts every 2 weeks. Such nurses bill independently using their own Medicaid number. Is the collaborative practice agreement enough documentation for an advanced practice nurse, with at least 60 percent of services billed by the nurse for calendar year (CY) 2012 for the designated codes, to be eligible for increased payments for those codes in CY 2013?**

Increased payment is available for services provided by eligible physicians or for services provided under their personal supervision. This means that the physician accepts professional responsibility (and legal liability) for the services provided. It does not appear that the collaborative arrangement requires that the physician accept professional responsibility for each of the services provided by the nurses. Therefore, increased payment would not be available.

However, if the physician *is required to accept professional responsibility* for the services provided by the advanced practice nurses *and the physician* is eligible based on self-attestation to a specified primary care specialty designation supported by either appropriate Board certification or a 60 percent claims history, then increased payment would be available.

**If the supervising physician does not self-attest to the physician specialty or subspecialty qualification, can the physician supervise a mid-level provider? If the supervising physician self-attests to the 60 percent threshold, but not one of the defined specialty or subspecialty qualifications, can the physician supervise a mid-level?**

The eligibility of services provided by mid-level/non-physician practitioners is dependent on 1) the eligibility of the physician and 2) whether or not the physician accepts professional responsibility for the services provided by the mid-level. As previously noted, the physician is eligible only if he **first self-attests** to a specified specialty designation and **also** to either being appropriately Board certified or having a 60 percent claims history.

**Is it permissible for States with Medicare geographic adjustments that opt to develop rates based on the mean Medicare rate over all counties for each Evaluation & Management code to use a weighted mean based on either the county population or the county Medicaid enrollment?**

We believe this would be acceptable. However, CMS would review the methodology as part of the SPA approval process.

**When does CMS plan to issue a correction to the mistake they noted during the call with Medicaid agencies regarding payment at the lesser of a provider's billed charge or the Medicare rate?**

The correction was published in the Federal Register on December 14, 2012. In it CMS clarified that states must reimburse providers the lower of the provider's charge or the applicable Medicare rate.

**If a state were to proceed with implementation on January 1, 2013, and submit a state plan by March 31, 2013, would CMS permit the state to claim the enhanced match for services that were reimbursed at the higher rate prior to approval of the state plan?**

No. As noted in the final rule, FFP in increased rates will not be available until the state plan amendment (SPA) is approved.

## Qs and As on the Increased Medicaid Payment for Primary Care

### CMS 2370-F (Set III)

**Our understanding of the rule is that advanced practice clinicians are eligible for the increased payment as long as they are working under the personal supervision of an eligible physician; eligible meaning the supervising physician is also eligible for the increased payment. We are trying to determine if: 1) the advanced practice clinician also can attest that they are working under the personal supervision of an eligible physician at the time of attestation, or 2) if they have to indicate who the supervising physician is on each claim for an eligible service and then we would need to see if that physician is eligible for the increased payment at the time of claim processing.**

**If an advanced practice clinician is billing under his/her own provider number, how can we know that he or she is under the personal supervision of an eligible physician?**

CMS has permitted states flexibility in establishing process to identify services provided by advanced practiced clinicians (APCs), including advanced practice nurses, being personally supervised by eligible physicians who accept professional responsibility for the services they provide. The state may set up a separate system to document that an APC is working under the personal supervision of a particular eligible physician. For example, the eligible physician could identify the APCs to the Medicaid agency, which could flag the claims submitted by those APCs under their own provider numbers through the MMIS. There is no requirement that the rendering provider indicate on each claim the name of the supervising eligible physician, however it is important that there be documentation that the eligible physician has acknowledged his relationship with the advanced practice clinicians. Providing this type of information on a per claim basis is an effective way to document the state's claim for 100 percent federal funding for the increased portion of the payment.

**Are Indian Health Services excluded from the increased provider payments? Is there any change in FMAP for primary care services delivered through IHS?**

IHS and tribal facilities are often not separately paid for physician services, but instead receive an all-inclusive rate for inpatient or outpatient service encounters. To the extent that a particular claim is made for primary care services furnished by an eligible physician, there is no exclusion from the requirement for provider payment at least equal to the Medicare Part B fee schedule rate. States would continue to receive FMAP at the 100 percent rate for services received through IHS and tribal facilities and reimbursed through the all-inclusive rate. For other physician services, including Medicaid payments for contract health services, states would receive the regular FMAP for the base payment, and 100 percent for the difference between the state plan rate in effect on July 1, 2009 and the applicable 2013 and 2014 Medicare rates.

**The preamble of the final rule makes it clear that salaried eligible physicians employed by counties must receive the higher payment for eligible E&M and vaccine services. Does this same logic apply to physicians employed by hospitals and, if so, is it CMS's expectation that the Medicaid agency will assure that the salaries of those physicians are increased?**

Physicians employed by hospitals whose services are reimbursed by Medicaid on a physician fee schedule must receive the benefit of higher payment. It is the Medicaid agency's responsibility

to ensure that hospitals receiving payments on behalf of those physicians comply with all requirements of the program. While hospitals could increase salaries they could also provide additional/bonus payments to eligible physicians to ensure that they receive the benefit of higher Medicaid payment.

**The final rule clarifies that the 60 percent threshold for eligibility is based on services billed. Are billed services to be defined based on the number of units submitted or dollars?**

The 60 percent threshold is based on the number of billed services as identified by individual billing codes for the primary specialty being asserted. That is, the numerator equals total billed codes for E&M services for the primary specialty, plus vaccine administration services, and the denominator equals the total number of billed codes. Please note that a state may choose to use paid billing codes/services in place of billed codes.

**For evaluating the claims history, must we use all “billed” claims, including denied claims or claims that are subsequently voided? We would propose to use all paid claims net of voids and adjustments.**

This is acceptable.

**If a physician does not provide an attestation by a date established by the State, can the State apply the increased payment prospectively only (that is, to dates of services on and after the date of attestation)? If not, are we correct that 42 CFR 447.45(d)(1) applies such that the claim for additional reimbursement is not payable if the attestation is not received within 12 months of the date of service?**

States can establish reasonable timeframes regarding the submission of attestations by physicians. We are aware that many states are experiencing delays in implementing the provisions of the regulation and we have also been made aware that there is considerable confusion on the part of providers regarding enrollment. We expect that states will provide physicians with ample notice of the procedures for enrollment that physicians will be given several months to comply with the requirements. If the state sets a reasonable timeframe, such as three months, and physicians do not enroll within that time, we believe that the state could make payment prospectively from the date of the physician’s application as long as this policy is made clear to providers.

**Does a physician have to self-attest in 2014 as well as 2013? The rule does not indicate that the physician has to self-attest a second time and we don’t want to do that, but some who qualified in 2013 (based on 2012 claims history) may not qualify in 2014 (based on 2013 claims history).**

You are correct that the rule does not require the physician to submit a new self-attestation in 2014 although states could impose such a requirement. States can rely on the initial self-attestation for purposes of 2014 payments since we would not expect provider practices to vary significantly from year to year.

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

Attestation forms are developed by the State Medicaid agencies. Physicians should contact their state Medicaid agency for information on the process for becoming eligible for higher payment in their state.

**While sports medicine is a subspecialty of internal medicine, it is also a subspecialty of non-primary care specialties. We would only qualify a physician for the board certification for the sports medicine subspecialty when it is a subspecialty of internal medicine. Is this correct?**

Yes, that is correct.

**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?**

The physician must first self-attest to a primary care designation of internal medicine, family medicine or pediatrics. This attestation signifies that the physician considers himself or herself to be an eligible specialty practitioner. The self-attestation must then indicate whether the physician considers himself or herself to be qualified because of appropriate Board certification or practice history as represented by a 60 percent claims history. Some physicians may be appropriately Board certified and have a 60 percent claims history.

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. If a physician supports his or her initial self-attestation with an attestation of appropriate Board certification, s/he can qualify only if s/he actually has the appropriate Board certification. Practice habits would not be applicable.

As we discussed in response to an earlier question, there may also 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.

**How should a physician who is certified in internal medicine, family practice or pediatrics by a Board other than the ABMS, the AOA or the ABPS self-attest?**

Such a physician would self-attest to a primary specialty designation of family medicine, pediatric medicine or internal medicine and would then attest to, and qualify based on, a 60 percent claims history.

**We understand that Deloitte (CMS's contractor) will be calculating the average GPCI values across counties for each state to use in paying primary care providers. When can we expect those values to be disseminated? Will the formula weight each county equally, or will some alternative weight be used based on county population or some other factor?**

CMS disseminated the Deloitte fee for service tool to states through the CMS Regional Offices in early January. It permits states to develop rates for each code based on the decisions it makes

about site of service and geographic adjustments. The formula used to develop the rate weights each county equally and does not incorporate a weighting factor for population. Using a rate weighted by population is not an option for states to use in developing their fee schedules.

**We received the Deloitte Excel model but have been unable to open some of the files. Can you help?**

CMS can produce the fee schedules for states that are unable to run the program. States should contact Christopher Thompson at [Christopher.thompson@cms.hhs.gov](mailto:Christopher.thompson@cms.hhs.gov).

**Community clinics in my state (clinics other than FQHCs and RHCs) are reimbursed at the same rate as a physician. They do not receive a bundled or encounter rate. Are they eligible for the higher payment? Would they have to attest that 60 percent of the services provided in the clinic are within the qualifying E&M codes? Are they required to pass through any increased payments in the form of higher wages for the health care professionals they employ?**

Higher payment made under the requirements of the regulation is for physicians reimbursed pursuant to a physician fee schedule. A physician working in a clinic and reimbursed through a physician fee schedule could qualify for higher payment if he or she is appropriately Board certified or if 60 percent of the services that he or she provides is for the specified primary care services. Since the clinic itself is not eligible, this percentage of services threshold cannot be based on the aggregate of all services provided by all practitioners within the facility, only on services the individual physicians.

**For physicians in neighboring states, can we require them to self-attest using our state's protocol, rather than relying on the determination made by the home state's Medicaid program?**

Yes.

**Qs &As on the Increased Medicaid Payment for Primary Care  
CMS 2370-F (Set VI)  
April 14, 2014**

**Please explain when salaried primary care providers are eligible for the enhanced payment under section 1202 and whether the employing organization, i.e. a clinic, physician group or hospital, may retain any additional payment received pursuant to this provision.**

Generally, the purpose of the 1202 payment increase is to directly benefit physicians performing primary care services. In the instance of salaried physicians, including those working for clinics or other employing organizations that bill on the Medicaid physician fee schedule, this could come in the form of an increased salary. Alternatively, where there is an employment agreement between the physician and the employing entity, the employment agreement might account for the payment increase by noting that the physician accepts his or her salary as payment in full, regardless of Medicaid reimbursement levels.

**Are there circumstances in which the enhanced payment under section 1202 will not be paid?**

To the extent that physicians are already receiving payment for Medicaid services that is at least equal to the Medicare rate as required under section 1202 of the ACA, no additional payment under section 1202 should be made to either a managed care health plan or to a group practice or similar organization that employs physicians. The additional payment is to ensure that payment to the physician is at least equal to the 1202 Medicare rate.

**If a state uses vaccine product codes to pay for vaccine administration, must it submit a new 1202 SPA when those product codes change?**

States that pay for vaccine administration using the vaccine product codes were required to include a crosswalk to their administration codes as part of their 1202 SPA. They will therefore be required to submit a new SPA to reflect any changes in those codes. If a state does not use vaccine product codes to pay for vaccine administration and therefore there is no crosswalk in their 1202 SPA, then no updates are necessary to reflect the code changes.

**Must a State submit a new SPA if it chooses to provide coverage for a new CPT billing code within the range of E&M codes specified in the law and regulation?**

Yes. The original SPAs contained a list of codes that had been added since 2009 that the state was planning on reimbursing at the higher 1202 rate. Therefore, if a state adds codes, it should submit a revised SPA page, updating that list of codes eligible for higher payment.

## **Qs and As on the Increased Medicaid Payment for Primary Care**

### **CMS 2370-F (set V)**

#### **Do allergists qualify for higher Medicaid payment under this regulation?**

CMS recently received information from the American Board of Medical Specialties attesting that the American Board of Allergy and Immunology (ABAI) is an ABMS-recognized sub-discipline of the American Board of Pediatrics and the American Board of Internal Medicine.

Specifically, the ABAI is a conjoint board of the American Board of Pediatrics (ABP) and the American Board of Internal medicine (ABIM). All physicians certified by the Board of Allergy and Immunology must first be board certified by either ABP or ABIM. Medical specialists certified by the Allergy and Immunology Board remain subspecialists of Internal Medicine and Pediatrics. However, it is possible that some holders of a certificate from ABAI will not have a current certificate in Internal Medicine or Pediatrics because some diplomats of the ABP and ABIM who hold subspecialty certificates are not required to maintain their primary certificates. The ABMS was concerned that these diplomats might be excluded from eligibility for higher payment under a strict interpretation of the rule even though they do act as their patients' primary care provider in many cases and urged that CMS formally recognize that diplomats of ABAI are, in fact subspecialists in Internal Medicine and Pediatrics and eligible for higher payment up to the Medicare rate.

Based on this information, CMS agrees that allergists are eligible for higher payment under the rule.

## **Qs & As on the Increased Medicaid Payment for Primary Care**

### **CMS 2370-F (Set IV)**

#### **May States delegate the self-attestation process to their contracted managed care plans?**

Yes. A state may elect to delegate the self-attestation process to its contracting health plans under the following circumstances:

1. Each managed care plan has signed documentation on file (provider contract or credentialing application) from the eligible provider attesting to the fact that he or she has a covered specialty or subspecialty designation. This addresses step 1 of the 2-step self-attestation process specified in the rule.
2. The managed care plan has verification of the provider's appropriate Board certification (as part of the credentialing and re-credentialing process). This addresses one option of the 2nd step in the self-attestation process.
3. Should Board certification in the eligible specialty not be able to be verified by the managed care plan, the eligible provider must provide a specific attestation to the managed care plan that 60 percent of their Medicaid claims for the prior year were for the HCPCS codes specified in the regulation. This addresses a second option for the 2nd step in the self-attestation process.
4. Such delegation is included in the contract amendment that is otherwise being filed to implement this provision.

#### **May practice managers or billing staff of large group practices and health systems attest on behalf of their physicians on the basis of information on Board certification in the records of the practice or health system?**

If these practices and health systems maintain the types of documentation described in the previous answer with respect to managed care organizations, attestation by the group or system would be acceptable. As previously noted, a physician actually must be practicing as an internist, pediatrician or family physician in order to be eligible for higher payment. Board certification does not always equate to practice characteristics. Therefore, attestation on the basis of information on Board certification alone would not suffice.

#### **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. CMS expects all information on self-attestation to be fully available to the state, regardless of which party collected this information.

**May physicians who practice in two (or more) states meet the 60 percent threshold based on all services provided in all states, or must they qualify on the basis of the services they provide in each state?**

States have the flexibility to count eligible services provided by a physician in neighboring states in meeting the 60 percent threshold, but are not required to do so.

**There are at least two CPT codes (99429 and 99499) for which there are no RVUs and the State manually prices the services for purposes of Medicaid payment. Will CMS develop a Medicare-like rate for these codes?**

These services would not be subject to the minimum payment standard set in the rule because there are no RVUs and there is no conversion factor associated with them. Therefore, a Medicare-like rate cannot be developed. The state may continue to reimburse them at the current Medicaid rate but enhanced FFP will not be available for those services.

**CMS has indicated that the CMS-64 will be modified for states to report the expenditures that will receive the 100 percent FMAP for the increased expenditures for primary care services. Will the CMS-21 also be modified to report these expenditures for the CHIP Medicaid Expansion population?**

No. The only expenditures that count against the CHIP allotment and must be reported on the CMS-21 are those related to the Medicaid rate in effect on July 1, 2009. The difference between those rates and the 2013 and 2014 Medicare rates eligible for 100 percent FMAP are Medicaid expenditures and are reported on the CMS 64.9.

**As we are working to implement ACA 1202, we found that we have to pay to access the ABMS website because use of the website for business or certification is strictly prohibited. Is CMS aware of what other states are doing? Is there some other way to access this information without paying?**

The state has two options: (1) it may claim this cost as an administrative expense of the Medicaid program; or, (2) it may require physicians to provide this documentation when they self-attest.

**We have questions regarding how far the state should go in verifying the self-attestation of a physician should that physician be selected for the annual audit. Specifically:**

- 1. if a physician self-attests to being a primary care provider and supports that attestation with evidence of appropriate Board certification, must we review that physician's practice to verify that s/he actually practices in that manner?**

No. Verification of current board certification is sufficient.

- 2. If a physician is board certified in a non-eligible specialty (for example dermatology) but practices within the community as for, example, a family practitioner and attests to meeting the 60 percent claims threshold, are we expected to audit his or her practice and, if so, how?**

Since the only evidence of eligibility is the self-attestation and claims history, the state would need to take steps to verify the practice characteristics of the physician. This could be done by determining that the physician represents himself in the community as a family practitioner, as evidenced by medical directory listings, billings to other insurers, advertisements, etc.

**We would like to be specific about our audit requirements in the State plan.**

While we have no objection to the addition of this information to the SPA, we believe it is more important that the state make providers aware of the audit procedures and requirements as part of the enrollment process.

**There are several codes for which there are RVUs, but a rate does not calculate for the non-facility setting. For example, 99217-99221 (observation codes) only have a facility fee. If the state is electing the option of paying the non-facility fee, should it use the facility fee or is there an alternative method for calculation?**

When there are RVUs for just one site of service the state should use those RVUs. There is no alternate method for calculation.

**In our state, the Medicaid agency instructs Rural Health Centers (RHCs) to bill the Medicaid agency for the administration of a VFC immunization by using the provider's individual provider number for each immunization administration and the RHC/Medicaid group number for payment to the RHC for other medical services. Do RHC's not qualify for enhanced payments on E&M codes billed with the RHC Medicaid facility provider number, but the individual providers do qualify for enhanced payment on VFC administration? Given that my state also requires RHCs to bill for E&M hospital codes such as 99221 or 99223 by using the individual treating provider's number, shouldn't the individual providers be "qualifying" providers for the purpose of enhanced payments for these hospital codes?**

Providers such as RHCs and Federally Qualified Health Centers (FQHCs) are reimbursed on the basis of an all-inclusive rate under their own Medicaid benefit categories. As specified in the final regulation, only services provided under the physician benefit and billed using a physician fee schedule are eligible for higher payment. In your examples, since the state reimburses the vaccine administration and the hospital codes on a fee for service basis and does not pay then all-inclusive rate, those services would be eligible for higher payment if the physician who provides

them properly self attests to eligibility. However, services provided by the physician that are reimbursed through the all-inclusive rate would not be eligible.

**We interpret 42 CFR 447.205 to not require public notice of a state's implementation of section 1202 of the ACA because "the change is being made to conform to Medicare methods or levels of reimbursement". Does CMS interpret this regulation differently?**

CMS agrees that 42 CFR 447.205(b)(1) exempts states from the public notice requirements when a change is being made to conform to Medicare reimbursement. However, states must still ensure that providers are properly notified of the requirements for self-attestation and higher payment through provider bulletins or other mechanisms.

**Are the services of "physician extenders" (defined as physicians who provide services in support of eligible physicians) eligible for higher payment when an eligible primary care specialist bills for their services? Examples of "physician extenders" include neurologists, OB/GYNs, pathologists, anesthesiologists and surgeons who provide services to the patients of eligible physicians.**

No. The only services that qualify are those provided directly by physicians (or by non-physician practitioners that they supervise) who self-attest to an eligible primary care designation and whose attestation is supported by evidence of Board certification or claims history. Physicians who do not qualify on their own merits cannot receive higher payment by having an eligible physician bill on their behalf. As previously noted, physicians must accept professional responsibility/liability for the services provided by non-physician practitioners under their supervision.



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

275 East Main Street, 6W-A  
Frankfort, KY 40621  
P: 502-564-4321  
F: 502-564-0509  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

May 7, 2014

**TO:** Jackie Glaze, Associate Regional Administrator, Division of Medicaid & Children's Health Operations, Centers for Medicare & Medicaid Services (CMS)

**RE:** Federal Financial Participation for primary care services provided in Community Mental Health Centers (CMHCs)

Dear Ms. Glaze:

Recently, Governor Beshear signed House Bill 527 into law (See Appendix A). The law amends Kentucky Revised Statute (KRS) 210:410 to allow for Community Mental Health Centers (CMHCs) to provide primary care services by advanced practice registered nurses (APRNs), physicians and physician assistants (PAs). In addition, the law states that the state Medicaid program or managed care organization or any other entity under contract with the Kentucky Department for Medicaid Services (DMS) shall provide for Medicaid reimbursement for primary care services for these providers employed by CMHCs at the Medicare levels per Section 1202 of the Affordable Care Act (ACA), if the CMHC is in compliance with the CMS regulations under that section.

We have looked into our own state laws and regulations and have found that there is nothing that prohibits DMS from authorizing CMHCs to participate as primary care providers. We have two questions for CMS:

- 1) Is there any federal rule that establishes guidance as to whether or not federal financial participation (FFP) may be provided for primary care services delivered in a CMHC setting?
- 2) Is there any federal rule that establishes guidance as to whether or not CMHCs providing primary care are eligible for FFP at the Medicare levels under Section 1202 of the ACA?

Jackie, we are trying to transform the health care delivery system in Kentucky. The role of CMHCs is rapidly changing, as are their funding methodologies. We believe the Medicaid patients with severe mental illness and developmental disabilities have come to rely on the CMHCs for their outpatient mental health needs. By allowing the CMHCs to provide physical health services coupled with mental health services, the CMHCs have an opportunity to become the "health home" to provide integrated care for these Medicaid patients.

Sincerely,

Lawrence Kissner  
Commissioner  
Department for Medicaid Services  
Cabinet for Health and Family Services  
Commonwealth of Kentucky

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Lisa Lee, Deputy Commissioner, Department for Medicaid Services  
Dr. John Langefeld, Medical Director, Department for Medicaid Services

AN ACT relating to community mental health centers.

***Be it enacted by the General Assembly of the Commonwealth of Kentucky:***

➔Section 1. KRS 210.410 is amended to read as follows:

- (1) The secretary of the Cabinet for Health and Family Services is hereby authorized to make state grants and other fund allocations from the Cabinet for Health and Family Services to assist any combination of cities and counties, or nonprofit corporations in the establishment and operation of regional community mental health and intellectual disability programs which ***may provide primary care services and*** shall provide at least the following services:
  - (a) Inpatient services;
  - (b) Outpatient services;
  - (c) Partial hospitalization or psychosocial rehabilitation services;
  - (d) Emergency services;
  - (e) Consultation and education services; and
  - (f) Services for individuals with an intellectual disability.
- (2) The services required in subsection (1)(a), (b), (c), (d), and (e) of this section, ***in addition to primary care services, if provided,*** shall be available to the mentally ill, drug abusers and alcohol abusers, and all age groups including children and the elderly. The services required in subsection (1)(a), (b), (c), (d), (e), and (f), ***in addition to primary care services, if provided,*** shall be available to individuals with an intellectual disability. The services required in subsection (1)(b) of this section shall be available to any child age sixteen (16) or older upon request of such child without the consent of a parent or legal guardian, if the matter for which the services are sought involves alleged physical or sexual abuse by a parent or guardian whose consent would otherwise be required.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

- (1) For the purposes of this section:**
- (a) "Advanced practice registered nurse" has the same meaning as in KRS 314.011;**
- (b) "Physician" has the same meaning as in KRS 311.550; and**
- (c) "Physician assistant" has the same meaning as in KRS 311.840.**
- (2) The Cabinet for Health and Family Services and any regional managed care partnership or other entity under contract with the cabinet for the administration or provision of the Medicaid program shall provide Medicaid reimbursement for primary care services provided by a licensed physician, advanced practice registered nurse, or physician assistant employed by a community mental health center established pursuant to KRS 210.370 to 210.480, if the community mental health center is in compliance with the Centers for Medicare and Medicaid Services regulations on enhanced primary care reimbursements.**
- (3) Primary care services provided by a physician, advanced practice registered nurse, or physician assistant in a community mental health center shall be subject to the same reimbursement rates as established by the Department for Medicaid Services for primary care providers operating in Kentucky.**
- (4) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section.**