CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 81	**Date: October 25, 2011**
	Change Request 7283

NOTE: Transmittal 80, dated September 27, 2011, is being rescinded and replaced with Transmittal 81 dated October 25, 2011 to reflect a change in zip codes allowed for Minnesota as reflected in Attachment VIII. All other information remains the same.

SUBJECT: Implementation Support and Payment Processing for the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration

I. SUMMARY OF CHANGES: The Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration is a three year demonstration to promote the principles of the advanced primary care (APC) practice, which is often referred to as the patient-centered medical home. Under this demonstration, CMS will join with Medicaid and commercial insurers to participate in existing State multi-payer medical home initiatives. Thus, each state program will vary both in design and payment requirements. However, under each of them CMS will pay a monthly care management fee for beneficiaries receiving primary care from APC practices. In some cases there will be additional fees paid by Medicare for community based care coordination services.

The following states will be participating in this demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. The requirements for each of the state program requirements are specified in this change request and the associated attachments.

Providers participating in the demonstration will continue to be eligible to receive their regular reimbursement for claims under the traditional fee-for-service Medicare program to the same extent they would in the absence of the demonstration.

EFFECTIVE DATE: July 1, 2011
IMPLEMENTATION DATE: CWF - July 5, 2011 implementation date
MCS – Analysis and Design: July 5, 2011 implementation date
Complete coding- October 3, 2011 implementation date

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):

Funding for implementation activities will be provided through an amendment to the contractor's current contract and funded by the Center for Strategic Planning's (CSP) Office of Research, Development and Information (ORDI).

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Funding for implementation activities will be provided through an amendment to the contractor's current contract and funded by the Center for Strategic Planning's (CSP) Office of Research, Development and Information (ORDI).

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One Time Notification

Pub. 100- 19	Transmittal: 81	Date: October 25, 2011	Change Request: 7283

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SUBJECT: Implementation Support and Payment Processing for the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration

Effective Date: July 1, 2011
Implementation Date: CWF - July 5, 2011 implementation date
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I. GENERAL INFORMATION

NOTE: These requirements only apply to contractors processing claims for providers (including some FQHCs), participating in this demonstration in the following states:

- Maine, Vermont, Rhode Island (J14)
- New York (J13)
- Pennsylvania (J12)
- North Carolina (J11)
- Michigan (J8)
- Minnesota (J6)

In addition, because Railroad Retirement beneficiaries shall be eligible for demonstration services, the specialty contractor (Palmetto) that processes claims for these beneficiaries shall be affected by this demonstration and these requirements.

Please also note that some of the requirements vary by state, as noted.

A. Background:

The Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration is a three year demonstration to promote the principles of the advanced primary care (APC) practice, which is often referred to as the patient-centered medical home. Advanced primary care practices, or "medical homes," utilize a team approach to care, with the patient at the center. APC practices emphasize prevention, health information technology, care coordination and shared decision making among patients and their providers. The goal is to improve the quality and coordination of health care services. For the purposes of this demonstration, an APC may be a solo practitioner, a group practice, or a federally qualified health center (FQHC). APC practices may be led by doctors or nurse practitioners.

Under this demonstration, CMS will join with Medicaid and commercial insurers to participate in existing State multi-payer medical home initiatives. Thus, each state program will vary both in design and payment requirements. However, under each of them CMS will pay a monthly care management fee for beneficiaries receiving primary care from APC practices. Additionally, each participating State will have mechanisms to offer APC practices community support and linkages to State health promotion and disease prevention initiatives. In some cases there will be two separate fees paid by Medicare: one to the APC practice and one to an organization that works with the practices to provide community based care

coordination services. In some cases, both of these payments are combined and are paid directly to the APC practice. Finally, in some situations, CMS will be paying an additional fee to the state for overall administration and evaluation of the program. In all of these situations, the fee is a monthly per beneficiary amount based on the panel of patients the practice is responsible for. The requirements for each of the state program requirements are specified in this change request and the associated attachments.

Providers participating in the demonstration will continue to be eligible to receive their regular reimbursement for claims under the traditional fee-for-service Medicare program to the same extent they would in the absence of the demonstration.

The following states will be participating in this demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. As shown in the table below, in some situations the demonstration will be state wide and include a large number of participating APCs while in others it will be more limited in scope geographically or in the number of participating practices.

State	Region	# Practices Participating *(By Year 3)*	Estimated Beneficiaries *(By Year 3)*
Maine	State-wide	42	80,000
Vermont	Initially: St. Johnsbury, Burlington, & Barre; planned statewide expansion	220	117,499
Rhode Island	State-wide	13	9,600
New York	Adirondack Region (N. Adirondack, Lake George, Tri Lakes)	35	30,976
Pennsylvania	Bucks, Montgomery, Philadelphia, Delaware, Chester, Wyoming, Lackawanna, Luzerne, Schuylkill Lehigh, Berks, Lancaster, Lebanon, Dauphin, Cumberland, York, Adams counties	78	71,846
North Carolina	Ashe, Avery, Bladen, Columbus, Granville, Transylvania, Watauga Counties	54	42,000
Michigan	State-wide	477	358,402
Minnesota	Generally state-wide (some counties excluded- see Attachment 8)	340	205,406

B. Policy:

For seven of the eight states participating in this demonstration (ME, VT, RI, NY, PA, NC, MI), the providers will not be required to submit claims in order to get the monthly medical home payment under the demonstration. For these 7 states, CMS will have a research contractor create a file with the information necessary to process claims for eligible beneficiaries and providers, community based organizations, and/or designated state entities. This file will be submitted to the MACs/carriers / who will then create and process individual (beneficiary level) claims, carrying out specific edits as noted in the Business Requirements below.

For the eighth state, Minnesota, providers will submit individual claims using specific procedure codes. The contractor will be expected to maintain a list of eligible demonstration providers (for Minnesota only)

and adjudicate the claims based on the list of eligible providers and the Minnesota-specific edits noted in the Business Requirements section of this CR.

The demonstration shall run for 36 months in each state. While it is expected that most states shall be operational July 1, 2011, start dates may be staggered by state. Should the demonstration start later in one or more states it will still run for the full 36 months in that state. Thus the demonstration may end on different dates in some states.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	I. Claims Processing And Payment- For All States Except Minnesota										
7283.1	Medical home practices, community health organizations or other designated state entities participating in this demonstration in the following states: ME, VT, RI, NY, PA, NC, and MI shall not be required to submit claims in order to be paid the monthly demonstration fee. Instead, on a monthly basis, the CMS research contractor will create and submit to each carrier/MAC and to MCS a file with information necessary to process an individual beneficiary level claim for a provider, community health organization or other state designated entity eligible to participate in the demonstration.	X			X			X			CMS research contractor
7283.2	The claim data file shall be submitted in a format to be mutually agreed to by the CMS research contractors and the contractors/maintainers and will contain, at a minimum, the following information: • Beneficiary Information: o Name and complete address (street, city, state, zip) o Medicare HIC o Date of birth o Gender • Rendering Provider Information • Provider Name • Provider NPI • Provider PIN • Billing Provider Information o Billing NPI (Group or Individual as appropriate) o Billing PIN (Group or Individual as appropriate)	X			X			X			CMS research contractor

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	o Provider Tax ID number *Note: All participating providers will be enrolled as Part B providers.* • Service Information o Date of Service (1st of month) o Place of Service o Procedure Code o Diagnosis o Submitted charge • Other Information o Demonstration Code ("58")										
7283.3	The following diagnosis code shall be used for processing MAPCP demonstration claims: V13.8 - Personal History of Other Diseases- Other Specified Diseases The contractor shall allow the use of this code but does not need to edit for this.	X			X			X			CMS research contractor
7283.4	The following Place of Service Code shall be used for processing MAPCP Demonstration Claims: 99 – Other Place of Service The contractor shall allow the use of this code but does not need to edit for this.	X			X			X			CMS research contractor
7283.5	The research contractor shall place on the claim data file the procedure code(s) and charges as provided in Attachments 1-7 for processing MAPCP Demonstration Claims. While most claims will have one line of service, in some situations, there may be two procedure codes (claim lines) for a single claim record. The Medicare payment contractors shall accept the billed charges put on the claim data file as the allowable charges to be used to process the claim	X			X			X			CMS research contractor
7283.6	The Medicare payment contractors shall use the file provided by the CMS research contractor to create, process and adjudicate individual claims for each beneficiary/ participating demonstration provider.	X			X			X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	These claims shall be processed as if they have been submitted electronically. The receipt date of the claim shall be the day the file is provided by the CMS Research Contractor. MCS shall create an automated process to download the file within one business day of it being provided. Standard timeliness requirements for processing claims shall be applicable.										
7283.7	Claims for providers that are sanctioned shall be denied. Normal sanction processes shall be followed. The contractor shall notify the CMS project officer and research contractor if a provider payment is denied due to sanctions. Notification shall be in the form of a report to be sent to both parties within 5 business days of the denial.	X			X						CMS project officer
7283.8	If a provider on the claim file is not eligible or is not found on the contractor's file, the contractor shall notify the CMS project officer and the CMS research contractor. Notification shall be in the form of a report to be sent to both parties within 5 business days of the denial.	X			X						CMS project officer & research contractor
7283.9	Demonstration services will not be included in the calculation of incentive payments such as those applicable to health professional shortage areas or medically underserved areas, the Physician Quality Reporting System, the E-prescribing incentive, etc.	X			X			X			Incentive specialty contractors
7283.10	The contractors shall not apply any copay or deductible to coverage for demonstration services. All demonstration claims shall be paid at 100% of the allowable charge which shall be the amount submitted on the claim data file by the CMS research contractor.	X			X			X		X	
7283.11	When adjudicating claims for demonstration services, the contractors shall not pay for services for beneficiaries (even if submitted on the "claims data file" by the research contractor) meeting the following criteria on the date of service: • Beneficiaries who are deceased; • Beneficiaries not having both Medicare part A & part B; • Beneficiaries who are not eligible for coverage under the Medicare fee-for service program on the date of service billed (i.e. not enrolled in a Medicare Advantage plan or other Medicare risk plan whereby FFS claims are not paid);	X			X					X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	• Beneficiaries for whom Medicare is not the primary insurer for all covered Medicare services (Working aged beneficiaries are not eligible for demonstration services; beneficiaries covered under workers compensation, auto liability, or other third party for specific services are be eligible for demonstration covered services.)										
7283.12	If information that would affect a beneficiary's eligibility for demonstration covered services is posted with a retrospective effective date, the contractor shall follow the standard processes that are already in place for looking back and re-processing claims. For example, if a demonstration claim is processed and subsequently the contractor learns the beneficiary was deceased on the date of service, the contractor shall take the same steps to recoup payment as it would for a regular Medicare fee for service claim. The contractor need not retrospectively adjust claims for a reason that they currently do not adjust for as part of the standard claims adjudication process.	X			X					X	
7283.13	The contractors shall use the appropriate remark and remittance advice codes to indicate that the beneficiary is not eligible for medical home services based on the above criteria. To extent that there are not more specific codes appropriate, contractors shall use the following Remittance Advice Remark Code: N30 Patient ineligible for this service	X			X						
7283.14	If any demonstration services are denied or rejected for any reason, the beneficiary shall not be liable for any payments.	X			X						
7283.15	Demonstration claims shall either be paid at 100% of the allowable charge or not paid because of beneficiary eligibility. While there may be no payment due from secondary insurers, these claims should be subject to the standard COB crossover procedures, if otherwise applicable.	X			X			X			
7283.16	All demonstration claim records, whether paid or not, shall include the special processing number of "58" to indicate it is associated with the MAPCP demonstration.	X			X			X		X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7283.17	Contractors shall process payments specific to each provider and state and procedure code as indicated in the file provided by the CMS research contractor and shown Attachments 1-7 to this CR. The contractors shall not be required to validate the procedure code and charge amounts provided by the CMS contractor on the "claims data file".	X			X			X			CMS research contractor
7283.18	The contractor shall suppress information on all demonstration covered services (whether paid or not) from the Medicare Summary Notices sent to beneficiaries	X			X						
	II. Claims Processing And Payment For Minnesota Practices										
7283.19	The contractor shall receive on a quarterly basis from CMS or its designated research contractor a file with information on medical home practices and their affiliated providers participating in this demonstration in Minnesota. All participating providers will be enrolled as Part B providers. For each participating medical home practice billing for services under the demonstration, the information shall include the following fields: 1.Practice name 2.Practice Address (street, city, state, zip) 3.Group P-TAN (Group PIN), if applicable Group NPI, if applicable*)* 5.Tax ID 6.Contractor ID *For providers servicing railroad retirement beneficiaries, information on the RR retirement payment contractor identification numbers will be provided separately from billing information for non RR retirement beneficiaries in Minnesota.* 7. Effective start date of participation for this practice 8. Effective termination date of participation for this practice For each individual rendering provider, the information shall include the following fields: 1.Practice affiliated with 2.Provider name 3.Individual NPI 4.Individual PIN	X			X						CMS research contractor

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	5.Effective start date of participation 6.Effective termination date of participation The format and final content of this file shall be mutually agreed to by the CMS research contractor and the payment contractor (MAC/carrier).										
7283.20	New practices/providers/organizations may be added or removed during the course of the demonstration. The contractor shall be able to update the above referenced provider information no less frequently than quarterly based on information provided from CMS and/or its research contractor.	X			X			X			CMS project officer; CMS research contractor
7283.21	The contractor shall establish and maintain on an ongoing basis a list of all of the practices, eligible for payment under the demonstration, including effective and termination dates, as appropriate.	X			X			X			
7283.22	Claims for providers that are sanctioned shall be denied. Normal sanction processes shall be followed. The contractor shall notify the CMS project officer and research contractor if a provider payment is denied due to sanctions. Notification shall be in the form of a report to be sent to both parties within 5 business days of the denial.	X			X						CMS project Officer
7283.23	Medical home practices in Minnesota shall submit claims for demonstration covered services in the same format as traditional Medicare fee for service claims. They may be paper or electronic.										Participating providers
7283.24	All demonstration claim records shall be submitted with the special processing number of "58" to indicate they are associated with the MAPCP demonstration. The demonstration code shall be submitted in the 2300 REF02 where REF01 is "P4". This is applicable to both the 4010A1 and 5010 electronic claim formats.									X	Participating providers
7283.25	Claims for demonstration services without this demonstration code shall be returned to the provider for re-billing with the demonstration code.	X			X			X			
7283.26	Claims for non demonstration services submitted with this code shall be returned to the provider for re-billing without the demonstration code.	X			X			X			
7283.27	Claims for demonstration services shall be submitted on their own claim and will not include on the same claim form services for non-demonstration services.										Participating providers
7283.28	Contractors shall reject claims for demonstration services	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	which are included on the same claim as non-demonstration (i.e. traditional Medicare services) services and direct providers to re-submit claims for demonstration services on a separate claim form.										
7283.29	The contractors shall only pay claims for services covered under the demonstration for providers and practices participating in the demonstration in Minnesota. Contractors shall use the following Remittance Advice Remark Code unless the contractor determines that another code is more appropriate: M115 This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	X			X			X			
7283.30	The contractors shall only accept one of the following Level 2 HCPCS codes to bill for covered demonstration services: • S0280 – Medical home program, comprehensive care coordination and planning, initial plan • S0281 – Medical home program, comprehensive care coordination and planning, maintenance	X			X						Participating providers
7283.31	The contractors shall accept certain modifiers submitted with demonstration claims. Providers must, include one of the following "tier level" modifiers when billing for either S0280 or S0281. U1 – Basic TF – Intermediate U2 – Extended TG – Complex Note: These modifiers have been recommended by the Administrative Uniformity Committee in Minnesota and are currently being used by Medicaid and commercial insurers in that state. They have been approved for use in the demonstration by the CMS HCPCS committee.	X			X						Participating providers
7283.32	The contractors shall adjust the allowable charges for S0280 and S0281 based on the presence of the above tier level modifiers as listed in the table in Attachment 8.	X			X			X			
7283.33	Providers will be eligible to receive a 15% increase in their payment for more complex patients. The contractors shall adjust the allowable charges for S0280 and S0281 based on the presence of complexity modifiers.	X			X			X			Participating providers

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	To indicate complexity, providers may, but are not required, to use one or both of the following supplemental complexity modifiers. U3- Primary language non-English U4 – Severe and Persistent Mental illness										
7283.34	As indicated in Attachment 8, payment rates for the basic tiers (S0280 or S0281 with one of the modifiers U1, U2, TF, or TG) will be increased by 15% for each of the complexity modifiers (U3 and/or U4) billed. For example, if a provider bills for a care coordination service with a U3 modifier only or a U4 modifier only, the allowable charge and payment will be increased by 15%. If a provider bills for care with BOTH a U3 and U4 modifier, the allowable charge and payment will increase by 30%.	X			X			X			
7283.35	The contractors shall not apply a copay or deductible to coverage for demonstration services. All demonstration claims shall be paid at 100% of the allowable charge.	X			X					X	
7283.36	The contractors shall not process claims for any given beneficiary for coverage for both S0280 and S0281 in the same calendar month regardless of who the billing provider is. Contractors shall use the following Remittance Advice Remark Code unless the contractor determines that another code is more appropriate: M86 Service denied because payment already made for same/similar procedure within set time frame.	X			X						
7283.37	The contractors shall only process a claim for any given beneficiary for payment for S0281 once per calendar month regardless of provider. Contractors shall use the following Remittance Advice Remark Code unless the contractor determines that another code is more appropriate: M86 Service denied because payment already made for same/similar procedure within set time frame.	X			X						
7283.38	If two medical home practices bill for S0281 in the same calendar month or one medical home practice bills for S0281 and another bills for S0280 in the same calendar month, the contractors shall only pay for the first service	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	submitted. The contractor shall not pay for the second service submitted and the appropriate remark/remittance advice codes shall be used. Contractors shall use the following Remittance Advice Remark Code unless the contractor determines that another code is more appropriate: M86 Service denied because payment already made for same/similar procedure within set time frame.										
7283.39	When adjudicating claims for demonstration services, the contractors <u>shall only pay</u> for services for beneficiaries meeting the following criteria on the date of service: • Reside in Minnesota but <u>not</u> in one of the Minnesota counties (as identified by zip codes) listed in Attachment 8 as excluded from the demonstration. For purposes of determining eligibility, the zip code submitted on the claim shall be used. • Are eligible for coverage under the Medicare fee-for service program on the date of service billed (i.e. not enrolled in a Medicare Advantage plan or other Medicare risk plan whereby FFS claims are not paid) • Are not deceased, • Have both Medicare Part A & Part B; • Have Medicare as the primary insurer (i.e. Working aged beneficiaries are not eligible for demonstration services; beneficiaries covered under workers compensation, auto liability, or other third party for specific services would be eligible for demonstration covered services.) If a claim is not paid due to the beneficiary not residing in the appropriate geographic area, contractors shall use the following Remittance Advice Remark Code unless the contractor determines that another code is more appropriate: N424 Patient does not reside in the geographic area required for this type of payment If a claim is not paid due to another reason for lack of patient eligibility, contractors shall use the following Remittance Advice Remark Code, unless other more specific codes are appropriate:	X			X			X		X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	N30 Patient ineligible for this service										
7283.40	If information that would affect a beneficiary's eligibility for demonstration covered services is posted with a retrospective effective date, the contractor shall follow the standard processes that are already in place for looking back and re-processing claims. For example, if a demonstration claim is processed and subsequently the contractor learns the beneficiary was deceased on the date of service, the contractor shall take the same steps to recoup payment as it would for a regular Medicare fee for service claim.	X			X			X		X	
7283.41	Demonstration services will not be included in the calculation of incentive payments such as those applicable to health professional shortage areas or medically underserved areas, the Physician Quality Reporting System, the E-prescribing incentive, etc.	X			X			X			Incentive specialty contractors
7283.42	If any demonstration services are rejected or denied for any reason, the beneficiary shall not be liable for any payments.	X			X			X			
7283.43	Demonstration claims shall either be paid at 100% of the allowable charge or not paid because of beneficiary eligibility. While there may be no payment due from secondary insurers, these claims shall be subject to the standard COB crossover procedures, if otherwise applicable.	X			X			X			
7283.44	The contractor shall suppress information on demonstration covered services from the Medicare Summary Notices sent to beneficiaries	X			X						
	III. Customer Support										
7283.45	The contractors shall work with participating providers and community entities to resolve all questions regarding processing of payment.	X			X						Participating providers
7283.46	Questions regarding payment policy or coverage under this demonstration that cannot be resolved shall be forwarded to the CMS project officer.	X			X						CMS project officer
7283.47	Claims processed under this demonstration are not subject to the normal appeals process.	X			X						Participating providers

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7283.48	There won't be a provider education article for this CR. However, CMS/ORDI and its state partners will be responsible for conducting any educational activities with the states. The contractor shall, however, be responsible for responding to questions specifically pertaining to payment processing.										CMS; states

IV. SUPPORTING INFORMATION

Please see Attachments for more detailed state specific processing information.

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jody Blatt (Jody.Blatt@cms.hhs.gov ; (410)786-6921))

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

Funding for implementation activities will be provided through an amendment to the contractor's current contract and funded by the Center for Strategic Planning's (CSP) Office of Research, Development & Information (ORDI).

Section B: *For Medicare Administrative Contractors (MACs)*:

Funding for implementation activities will be provided through an amendment to the contractor's current contract and funded by the Center for Strategic Planning's (CSP) Office of Research, Development & Information (ORDI).

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachments

I. Maine
    a. Procedure Codes and Allowed Charges

II. Vermont
    a. Procedure Codes and Allowed Charges

III. Rhode Island
    a. Procedure Codes and Allowed Charges

IV. New York
    a. Procedure Codes and Allowed Charges

V. Pennsylvania
    a. Procedure Codes and Allowed Charges

VI. North Carolina
    a. Procedure Codes and Allowed Charges

VII. Michigan
    a. Procedure Codes and Allowed Charges

VIII. Minnesota
    a. Beneficiary Eligibility Requirements
    b. Procedure Codes and Allowed Charges

ATTACHMENT I: MAINE

b. Procedure Codes and Allowed Charges

HCPCS Code	*Description*	*Payable To*	*Allowable Charge*
G9008	Physician Coordinated Care Oversight Services	Medical Home practice	$7.00
G9152	MAPCP Demonstration – Community Health Teams	Community Based Entity	$2.90

ATTACHMENT II: VERMONT

a. Procedure Codes and Allowed Charges

HCPCS Code	***Description***	***Payable To***	***Allowable Charge***
G9008	Physician Coordinated Care Oversight Services	Medical Home practice	$1.20 - $2.49 ***<u>IMPORTANT NOTE:</u> For Vermont, the payment rate for G9008 will vary for each medical home based on score. The state will provide the rate for each medical home***
G9152	MAPCP Demonstration – Community Health Teams	Community Based Entity (includes SASH & CHT)	$4.57 (Payment rates may be updated annually)

ATTACHMENT III: RHODE ISLAND

a. Procedure Codes and Allowed Charges

HCPCS Code	***Description***	***Payable To***	***Allowable Charge***
G9002	Coordinated Care fee – Level 1	Medical Home Practices – Group 1 practices (newer)	$3.00 or $4.16 *($3.00 goes to practices for which there is a separate community health team fee paid to the local hospital. Where the practice provides this service, the fees are combined. In 2012, these rates will be updated in accordance with a new contract.)* fee to be adjusted annually) Payment amount will be on file provided CMS research contractor
G9005	Coordinate Care Fee (Level 2)	Medical Home Practices – Group 2 practices (older)	$5.50 *(This fee may be adjusted*

			annually based on a practice meeting performance benchmarks. The potential fee in future years will be $5.00, $5.50, or $6.00 pbpm.)
G9152	MAPCP Demonstration – Community Health Teams	Community Based Entity	$1.16 (fee to be adjusted annually)
G9151	MAPCP Demonstration –State Provided Services	State designated entity	$0.28 (fee to be adjusted annually)

ATTACHMENT IV: NEW YORK

b. Procedure Codes and Allowed Charges

HCPCS Code	*Description*	*Payable To*	*Allowable Charge*
G9008	Physician Coordinated Care Oversight Services	Medical Home practice	$7.00

ATTACHMENT V: PENNSYLVANIA

a. Procedure Codes and Allowed Charges

Each month, a practice is eligible for the basic medical home fee (G9008) plus a care management fee (G9002, G9005, G9009 *or* G9010). Only one care management fee can be paid for any beneficiary in any one month. Which code to pay is determined by the beneficiary's age on the date of service (first day of the month)

HCPCS Code	***Description***	***Payable To***	***Beneficiary Age***	***Allowable Charge***
G9008	Physician Coordinated Care Oversight Services	Medical Home practice	Any Age	$1.50
G9002	Coordinated Care fee – Level 1	Medical Home Practices	Beneficiary 18 years of age or younger	$0.60
G9005	Coordinate Care Fee (Level 2)	Medical Home Practices –	Beneficiary 19-64 years of age	$1.50
G9009	Coordinated Care Fee (Level 3)	Medical Home Practices –	Beneficiary 65-74 years of age	$5.00
G9010	Coordinated Care Fee (Level 4)	Medical Home Practices – Beneficiary <= 64 years of age 1	Beneficiary >=75 years of age	$7.00

ATTACHMENT VI: NORTH CAROLINA

a. Procedure Codes and Allowed Charges

HCPCS Code	*Description*	*Payable To*	*Allowable Charge*
G9148	National Committee for Quality Assurance – Level 1 medical home	Medical Home Practices – NCQA Level 1	$2.50
G9149	National Committee for Quality Assurance – Level 2 medical home	Medical Home Practices – NCQA Level 2	$3.00
G9150	National Committee for Quality Assurance – Level 3 medical home	Medical Home Practices – NCQA Level 3	$3.50
G9152	MAPCP Demonstration – Community Health Teams	Community Based Entity	$6.50

IMPORTANT NOTE: ***For North Carolina, individual practices may change which procedure code they bill during the course of the demonstration based on achievement of a higher NCQA certification level. It will be the responsibility of the state to notify the contractor through its update files of which practices are eligible to bill under which codes for which period of time.***

ATTACHMENT VII: MICHIGAN

a. Procedure Codes and Allowed Charges

HCPCS Code	*Description*	*Payable To*	*Allowable Charge*
G9008	Physician Coordinated Care	Medical Home practice	$2.00
G9151	MAPCP Demonstration – state provided services	State designated entity	$0.26
G9152	MAPCP Demonstration – Community Health Teams	State designated entity	$4.50
G9153	MAPCP Demonstration – Physician Incentive Pool	State designated entity	$3.00

ATTACHMENT VIII: MINNESOTA

a. Beneficiary Eligibility Requirements

In order to be eligible to participate in this demonstration and have claims paid, beneficiaries must reside in Minnesota but NOT in any of the following counties:

- Fillmore
- Houston
- Olmsted
- Winona

For purposes of determining counties the zip codes in the table in section C of this attachment should be used.

In addition, the beneficiary must meet the following requirements as of the date of service on the claim:

a. Have both Medicare Parts A & B;
b. Are eligible for coverage under the Medicare fee-for service program on the date of service billed (i.e. not enrolled in a Medicare Advantage plan or other Medicare risk plan whereby FFS claims are not paid, not be deceased.); and
c. Have Medicare as the primary payer for all covered Medicare services (i.e. not be working aged);

b. Procedure Codes and Allowed Charges

Procedure		Tier Level Modifier			Allowable Charge	Allowable Charge with One Supplemental Complexity Modifier	Allowable Charge with Two Supplemental Complexity Modifiers
Code	Description	Modifier	Tier	Description			
S0280	Medical Home Program, comprehensive care coordination & planning, initial plan *(Note- In general, claims with no modifiers will not be billed as they are not eligible for payment.)*	(none)	0	Low	$0.00	$0.00	$0.00
S0280	Medical Home Program, comprehensive care coordination & planning, initial plan	U1	1	Basic	$ 10.14	$ 11.66	$ 13.18

Procedure		Tier Level Modifier			Allowable Charge	Allowable Charge with One Supplemental Complexity Modifier	Allowable Charge with Two Supplemental Complexity Modifiers
Code	Description	Modifier	Tier	Description			
S0280	Medical Home Program, comprehensive care coordination & planning, initial plan	TF	2	Intermediate	$ 20.27	$ 23.31	$ 26.35
S0280	Medical Home Program, comprehensive care coordination & planning, initial plan	U2	3	Extended	$ 30.00	$ 34.50	$ 39.00
S0280	Medical Home Program, comprehensive care coordination & planning, initial plan	TG	4	Complex	$ 45.00	$ 51.75	$ 58.50
S0281	Medical Home Program, comprehensive care coordination & planning, maintenance *(Note- In general, claims with no modifiers will not be billed as they are not eligible for payment.)*	(none)	0	Low	$0.00	$0.00	$0.00
S0281	Medical Home Program, comprehensive care coordination & planning, maintenance	U1	1	Basic	$ 10.14	$ 11.66	$ 13.18
S0281	Medical Home Program, comprehensive care coordination & planning, maintenance	TF	2	Intermediate	$ 20.27	$ 23.31	$ 26.35
S0281	Medical Home Program, comprehensive care coordination & planning, maintenance	U2	3	Extended	$ 30.00	$ 34.50	$ 39.00
S0281	Medical Home Program, comprehensive care coordination & planning, maintenance	TG	4	Complex	$ 45.00	$ 51.75	$ 58.50

Supplemental Complexity Factor Modifier(s)				Impact on Allowable Charge
Modifier 1		Modifier 2		
U3	Primary Language Non-English	(none)	(none)	Increase by 15%
(none)	(none)	U4	Severe & Persistent Mental Illness	Increase by 15%
U3	Primary Language Non-English	U4	Severe & Persistent Mental Illness	Increase by 30%

c. Excluded counties and associated zip codes

County	Zip
FILLMORE	55922
FILLMORE	55923
FILLMORE	55935
FILLMORE	55937
FILLMORE	55939
FILLMORE	55949
FILLMORE	55954
FILLMORE	55961
FILLMORE	55962
FILLMORE	55965
FILLMORE	55971
FILLMORE	55975
FILLMORE	55986
FILLMORE	55990

County	Zip
HOUSTON	55919
HOUSTON	55921
HOUSTON	55931
HOUSTON	55941
HOUSTON	55943
HOUSTON	55947
HOUSTON	55974
OLMSTED	55905
OLMSTED	55920
OLMSTED	55929
OLMSTED	55934
OLMSTED	55960
OLMSTED	55976
OLMSTED	5590X

County	Zip
WINONA	55910
WINONA	55925
WINONA	55942
WINONA	55952
WINONA	55959
WINONA	55969
WINONA	55972
WINONA	55979
WINONA	55987
WINONA	55988