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Frequently Asked Questions About Affordable Care Act (ACA) 1202 Primary Care Physician Increase

Q. Where is the link to the state attestation database?

A. Please Click here to access the Medi-Cal website and continue to ACA Self Attestation Form.

Q. How do I know if my attestation is accepted?

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

- *Provider attestation is automatically retroactive to January 1, 2013, except in two circumstances:*

  i. *If the provider is eligible based on board certification, but not claim history, the attestation is only retroactive to the begin date of the board certification if that is after January 1, 2013.*

  ii. *If the provider is newly enrolled in the Medi-Cal program, the attestation would only be retroactive to the date of enrollment.*

- *Providers who are incorrectly deemed automatically eligible retroactive to January 1, 2013, should submit an update to the attestation information as described in the Affordable Care Act – Primary Care Physician Self Attestation Form Completion Instructions.*

Q. I completed an attestation and the state advised I did not qualify. What can I do to receive the payment?

A. *Only providers who have attested and qualify per state eligibility requirements will be accepted into the program. Click here to review eligibility requirements at the top of the state website page.*

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Q. How do I create, change or cancel an existing attestation?

A. Click here to go to the following Medi-Cal landing page.

Q. I am having trouble completing the attestation form online. Can you please assist me?

A. Click here to review instructions on how to complete the attestation form.

Q. How long does it take to attest with the state?

A. Currently, we are not aware of any timelines associated with the state's review of your qualifications. If you have specific questions concerning the timing, please contact DHCS directly.

Q. Why do I have to complete a W9 form?

A. The program requirements state that we must send reimbursement payments directly to the rendering providers. Therefore, to ensure all reimbursements are directed to the appropriate address, we require all providers to complete the W9 form with the accompanying cover letter. We will not be able to process any reimbursements without a signed W9.

Q. Where do I send the completed W9 form?

A. Please fax to: 1-(888) 310-3660. Please also make sure you complete and return the cover letter as well.

Q. How often do I have to fill out the W9?

A. Only once. It will remain in effect unless you submit a replacement.

Q. Can I change my W9 information?

A. Yes. All you need to do is complete a new form and fax to: 1-(888) 310-3660.

Q. How do I know if I'm eligible for this differential payment?

A. To be eligible for the ACA and 42 CFR 447 enhanced payments, the physician rendering or supervising the service must personally attest to be the following:

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A physician, as defined in 42 CFR 440.50 with a specialty designation of family medicine, general internal medicine, pediatric medicine or a subspecialty within one of the listed specialties.

AND Meeting at least one of the following qualifications:

Board certified in a specialty or subspecialty that is recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS) or American Osteopathic Association (AOA). Please see the "Related Links" section of this page for links to additional information.

OR

At least 60 percent of total claim volume for the most recently completed calendar year or, for newly eligible physicians, the prior month, were for E&M (99201 – 99499) and Vaccine Administration (90460, 90461, 90471 – 90474, or their successors) services or local codes that correspond to these E&M and Vaccine Administration codes.

Q. When will I get my first check?

*A. As long as you have attested with DHCS by **December 31, 2014** and sent GCHP a completed W9 by Feb. 2014, the initial payments were made in March of 2014 for the service period: 1/1/13 - 6/30/13. The next payment run is scheduled for mid-December 2014 for the service period: 1/1/13 - 12/31/13. Future payment runs will be based on funding from DHCS.*

Q. Can I get my checks via direct deposit or bank transfer instead?

A. Unfortunately, we can only process paper checks.

Q. Can I defer my payments to the next calendar/fiscal year?

A. Unfortunately, we cannot delay or withhold any payments under this program

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Q. I am an out of state provider. I provided services to one of your members and received the claim payment. I did not receive the ACA PCP Rate bump payment. How can I get a check for the bump payment?

A. CMS requires you to attest with the state of CA before GCHP can validate state attestation acceptance and review for possible payment. Click here to access the Medi-Cal website.

Also, you will be required to complete a W9 form and cover letter and send it back to us so we can load your profile in the system. Click here to access the form under the ACA section at the GCHP website.

Please fax completed forms to: 1-(888) 310-3660.

Q. Why was there such a delay since the last set of ACA 1202 payments?

A. *The State of California has not been timely in delivery of funds to the health plans. Funds covering the period July 2013 through December 2013 were only received recently by Gold Coast Health Plan. In addition, following the initial distribution of checks from Gold Coast Health Plan to providers in March 2014, the state informed Gold Coast Health Plan that we would need to implement changes to our processes. Those changes would have required that Gold Coast Health Plan implement retroactive rate changes that would have required recouping of funds already made to providers. It was decided instead to put all ACA1202 payment processing on hold until all details could be worked out between the State and the Ventura County Board of Commissioners. Most of the issues have been resolved and a new set of checks should be delivered to providers by mid-December 2014 covering the full calendar year 2013.*

Q. What is the "Lesser-of" methodology?

A. *The directive from CMS regarding calculation of payments to providers under the ACA1202 program state that providers may be reimbursed for qualified services up to the maximum calculated Medicare rate, but total reimbursement between the original Medi-Cal payment and the ACA1202 payment may not exceed the provider's billed amount for the service. Therefore, to determine the ACA1202 payment, the previous claim payment is subtracted from the lesser of the ACA1202 Medicare rate or the provider's billed amount.*

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Q. What happens to services that have already been paid?

A. *The Ventura County Board of Commissioners has decided to pay ALL services for the first half of 2013 at the full ACA1202 rates without applying the "Lesser of" methodology. The alternative would have been to request refunds from providers or deduct those amounts from future payments. The Commission voted to let providers keep those extra funds.*

Q. Are there any exceptions?

A. *We are aware that the state had previously instructed providers of CHDP services to submit claims with a billed amount equal to that of the expected Medi-Cal payment. Using the lesser-of methodology, this would result in little or no reimbursement under the ACA1202 program. The state is aware of this issue and plans to issue special directives for reimbursing providers of CHDP services. However, until such direction is given, Gold Coast Health Plan will apply the "lesser-of" methodology to all CHDP claims starting with dates of service on or after July 1, 2013, then issue corrective payments at a later date.*

Q. I am not a CHDP provider but I have submitted claims with a reduced billed amount to reflect the expected payment. Can I resubmit my claims with the correct billed amount?

A. Resubmission of a claim that was previously adjudicated and paid will result in the claim being denied.