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AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

June 7, 2012

VIA ELECTRONIC SUBMISSION TO WWW.REGULATIONS.GOV

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2370-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-2370-P, Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children

Thank you for the opportunity to review and comment on the proposed rule published at 77 Federal Register, No. 92, on May 11, 2012 (CMS-2370-P), to implement provisions of the Affordable Care Act of 2010 (ACA) that would give certain primary care physicians (PCPs) rendering specific services a reimbursement rate at least equal to Medicare rates. The Arizona Health Care Cost Containment System (AHCCCS) is the State agency that administers Arizona's Medicaid program, the Children's Health Insurance Program (known as KidsCare), and other health programs which are responsible for providing quality health care coverage to more than 1.28 million Arizonans. Our comments are listed below.

§§ 438.6 and 438.804 Applicability to Managed Care Plans
The proposed rule extends increased minimum payment levels for specified services by eligible providers participating with managed care plans. Specifically, 42 CFR 438.6(c)(3)(v) and 6(5)(vi) require managed care contracts to comply with new minimum payment levels, make those payments to physicians, and provide documentation to the state regarding the amount payments increased. The regulation also adds 42 CFR 438.804, which specifies that 100 percent FFP is available for the portion of the expenditures for capitation payments made under those contracts that comply with contractual requirements under 438.6(c)(5)(vi) only when certain requirements are met.

While the proposed requirements attempt to uniformly implement the payment increase and ensure eligible providers receive the full Medicare rate, the suggested approach creates significant administrative and financial burdens for Arizona. The proposed rule in 438.6(c)(5)(vi)(B) requires states to include managed care organization reports for justification of increased capitations. Arizona sets capitation rates based on multiple factors, including encounter data of all services provided by the plans. The State will estimate the increased capitation across all plans necessary to cover the increased cost of the services using the encounter data. Therefore, no specific reports from individual plans are necessary. Additionally, because the development of actuarially-sound capitation rates for a future period cannot typically predict exact expenditures for a given service, AHCCCS is concerned that CMS may expect that reports from MCOs during that future time period be used to reconcile the capitation adjustment to the actual expenditures.

Therefore, AHCCCS recommends that states be provided more flexibility to submit their own actuarially sound methodology for CMS approval for claiming the enhanced FMAP associated with the increased capitation. Additionally, AHCCCS recommends that CMS clarifies their intent regarding the MCO reports.

§447.400 Primary care services furnished by physicians with a specified specialty or subspecialty
As proposed, all specialists and subspecialists in family medicine, general internal medicine, and pediatric medicine as designated by the American Board of Medical Specialties, would be eligible for increased payments, and states must verify their eligibility in that specialty or subspecialty. The proposed rule extends this for physicians who are not certified by the American Board of Medical Specialties. States would be required to confirm eligibility by conducting a review of the physicians billing history to ensure they have furnished certain services equal to at least 60% of the Medicaid codes billed. The Proposed Rule also specifies what services constitute primary care services when provided by these designated providers.

These proposals present several significant challenges to AHCCCS:

Identification of specialists and subspecialists
All specialty designations are self-reported without any current standardized method to verify the accuracy of that report. Board certification is not confirmed at a national level in the assignment of taxonomy and National Provider Identification (NPI) numbers. Therefore, states should not be required to confirm specialty designation at the state level.

Therefore, AHCCCS recommends that states be permitted to rely on CMS assignments of NPI taxonomy.

Calculation of the 60% service requirements
Any calculations of the percentage of primary care services provided by a physician create an additional administrative burden. This cannot be calculated until all claims for the year are submitted and adjudicated by the managed care organizations, transmitted to AHCCCS as encounters, and percentage calculations performed on an individual provider basis. This data is not complete for up to 12 months following the end of the fiscal year, making it a near-impossibility to pay new providers appropriately on a timely basis. AHCCCS recommends that it and other Medicaid programs be allowed to pay self-designated specialists and subspecialists under the enhanced fee schedule without regards to the percentage of primary care services provided. Furthermore, it should be noted that board certified specialists and subspecialists are not subject to any percentage thresholds of primary care services to qualify for the enhanced fee levels.

Therefore, AHCCCS recommends that non-board certified specialists and subspecialist providing primary care services be treated in a similar manner.

Specialists and subspecialists acting in the role of consultants
Under proposed Rule 447.400(a), it appears that CMS will require that all physicians designated as family medicine, general internal medicine or pediatric medicine or any of the subspecialties included under those specialties will be paid at the Medicare rate for 2013 and 2014. Is this the case even when a physician is acting as a subspecialist or a consultant to treat a specific medical problem on referral from the member's primary care physician? Claims for subspecialists' Evaluation and Management (E&M) services will utilize the same codes as claims from primary care specialists. For example, a pediatric cardiologist who is board certified in both pediatrics might be asked by a member's primary care pediatrician to evaluate a heart murmur. The subspecialist physician will likely submit a claim that includes a HCPCS code describing an office visit E&M service. Should AHCCCS or its MCOs pay such claims at the enhanced Medicare rate as if it is a primary care service rather than a specialist evaluation?

Therefore, AHCCCS recommends that CMS clarifies its intent regarding payment to these specialists and subspecialists in their various roles when providing health care services.

Eligible primary care services
Under proposed Rule 447.400(b)(1), it appears that CMS considers all Evaluation and Management (E&M) codes in the range of 99201-99499 as primary care services, when in fact some of these codes describe services that are not typically considered "primary care" services. For example, visits to an Emergency Department for acute injuries as the result of an accident are not typically considered primary care but are described by HCPCS codes 99281-99285, which are within the given range. Similarly, critical care services in an intensive care unit or other hospital location are not typically considered "primary care" services but are described by HCPCS codes 99291-99292, which are within the given range. Is it the intent of CMS to pay for all E&M services described by HCPCS codes 99201-99499 provided by a physician designated as one of the three named specialties and subspecialties at the Medicare rate for 2013 and 2014, even if the services are not typically considered primary care services?

Therefore, AHCCCS recommends that CMS clarifies whether it considers all medical services described by HCPCS codes 99201-99499 as primary care services.

Services not reimbursed by Medicare
On page 27676 of the Proposed Rule, CMS states that it is proposing to include as primary care services certain services that are not reimbursed by Medicare and lists the codes for those services. Absent from this list are the HCPCS codes 99241-99255 that describe Consultation services, which Medicare no longer covers. However, AHCCCS continues to cover these services. Does CMS intend that when Medicaid covers Consultation services as described by HCPCS codes 99241-99255, which are within the range of primary care services described in the Proposed Rule, that Medicaid would pay physicians who meet the defined criteria as primary care providers at the rate that Medicare would pay if it covered those services? That is, would the required fee be at the Relative Value Units listed on the Medicare Physician Fee Schedule times the Medicare conversion factor?

Therefore, AHCCCS recommends that CMS clarifies whether it will provide enhanced FFP for consultation services and other services not covered by Medicare when paid at the imputed Medicare rate.

Primary Care Services provided by physician extenders
On page 27676 of the Proposed Rule, CMS states that primary care services provided by a nurse practitioner or physician assistant under the personal supervision of a physician who is enrolled as one of the designated specified primary care specialists or subspecialists would be paid at the higher rate if billed under the physician's provider number. AHCCCS requires licensed professionals to bill under their own NPI number even when providing services under the supervision of a physician. In addition, Arizona allows nurse practitioners to provide primary care services without being supervised by a physician. If state law permits such independent practice, is it CMS' intent to not pay for those services at the Medicare rate? Also, if nurse practitioners provide primary care services under the direction of a physician but submit claims with their own NPI as required by some state Medicaid programs, is the increased FFP available to states that pay for those services at the Medicare rate?

Therefore, AHCCCS recommends that CMS clarifies the availability of enhanced FFP funds for primary care services provided by nurse practitioners and physician assistants operating within their state-designated scope of practice limits.

§447.405: Amount of Required Minimum Payments
Vaccines provided under the Vaccines For Children (VFC) Program
Under Proposed Rule 447.405(b), for vaccines provided under the VFC Program, States **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. However, on page 27682 of the Proposed Rule, CMS states that "State Medicaid agencies would not be obligated to set the Medicaid payment for vaccine administration at the level of the maximum fees set forth in this proposed rule."

Therefore, AHCCCS recommends that CMS clarifies whether payments at the higher fee levels are required, as indicated by the proposed rule language, or permissive as indicated in the Preamble language.

§447.410 State Plan Requirements
The rule requires an approved State Plan Amendment (SPA) to reflect the increase in fee schedule payments for CY 2013 and 2014 before increased Federal Financial Participation (FFP) can be made available. More information is needed about the contents of the SPA, such as the final requirements for the verification of provider eligibility, identification of applicable rates and any mid-year updates.

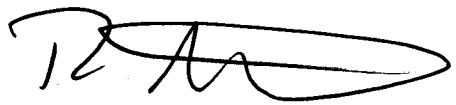
Therefore, AHCCCS requests that SPAs be made retroactive to the quarter in which they are submitted, as is the current process. In addition, AHCCCS requests an automatic sunset date be included in the SPA to reduce administrative burden.

Regulatory Impact
AHCCCS reviewed the proposed revisions and compared them to other programmatic changes underway in the Agency at this time, such as 5010 implementation and the upcoming ICD-10 conversion, to assess the relative administrative and financial burden on our program. AHCCCS believes the regulatory impact statements and estimates of costs and time to implement these changes are grossly understated. We believe it will require significant personnel and financial resources to make the necessary changes in our systems for a relatively short two-year implementation period.

Therefore, AHCCCS recommends that CMS engage the states to more accurately and realistically assess the burdens placed on them by these short term changes.

I appreciate this opportunity to comment on the proposed rules and to provide Arizona's perspective regarding these provisions. Please contact my office if you have any questions or concerns.

Sincerely,



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