June 11, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program, Proposed Rule, 77 Federal Register 27671, May 11, 2012

Dear Ms. Tavenner:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the proposed rule, Medicaid Program: Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program, Proposed Rule, 77 Federal Register 27671, May 11, 2012.

AHCA is the nation’s largest association representing long term and post-acute care providers. Our 11,000 members include profit and not-for-profit skilled nursing facilities, assisted living residences, subacute centers, and homes for persons with mental retardation and developmental disabilities. Our members are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily to more than 1.5 million of our nation’s frail, elderly, and disabled citizens.

We recognize the important role of primary care physicians (PCPs) and non-physician practitioners in the health care system. Given the array of health care needs of the patients and residents our members serve and the challenges Medicaid beneficiaries often face finding physicians who will accept Medicaid, AHCA applauds CMS’ efforts to improve the payment rate for PCP services and improve access to care for Medicaid enrollees. To help ensure the success of this initiative, AHCA has the following suggestions and comments about the proposed rule:

1. **Clarify how subcontracted physicians and specialty physicians services may be billed.** Physician services, in particular, geriatrician services, may be included in nursing facility rates. And, in turn, some facilities contract with physicians and specialists directly. In such scenarios, since the physician services are part of the nursing facility per diem rate, the physician does not submit a claim using their unique Medicaid provider identification number. CMS should clarify how the enhanced matching should be structured in such scenarios.
II. The temporary payment increase must address unintended consequences. The enhanced payment rate is available for only two years and CMS acknowledges that it is unclear whether states have the ability to sustain this payment level to providers beyond 2014. And, as noted above, finding physicians willing to accept Medicaid often is problematic. Estimates indicate that up to 16 million people may gain coverage through the Affordable Care Act’s (ACA’s) expansion of the Medicaid program, which will increase demand for PCP services. At the same time, state budgetary projections indicate several more years of tight Medicaid budgets. AHCA recognizes that the additional populations covered under the Medicaid expansion will be 100 percent federally funded in 2014 and gradually phase down to 90 percent in 2020. Since this expansion population will require access to a wide range of Medicaid services, including personal care or other long term services and supports, AHCA urges CMS to explore whether it has the authority to phase down the increased payments to PCPs in the same manner as matching for the expansion population. At its core, the ACA is intended to expand coverage and access. Considering state budget challenges, a precipitous drop in the PCP payment increase could create access issues.

III. CMS should make administration of the PCP payment increase as easy as possible. PCP enhanced matching, while likely improving beneficiary access to physician services, comes at a time when states must implement a number of other ACA provisions and many states are facing staffing shortages due to layoffs, early retirement, and hiring freezes. The proposed rule provides states with the option to comply with the requirement by either adopting annual rates or by using a methodology to update rates to reflect changes made by Medicare during the year, but proposes that they use the Medicare Physician Fee Schedule rate applicable to the site of service and geographic location of the service at issue. Considering the circumstances under which states must implement this requirement, listed above, AHCA suggests CMS also provide states with the flexibility to determine the applicable rate paid.

IV. Regarding rate setting, CMS should consider using the same requirements set forth in Section 2001(c) of the ACA which modified the Deficit Reduction Act Benchmark Benefit Plan state plan option. Specifically, CMS requested comments regarding the most appropriate way to set rates for services not reimbursed by Medicare. AHCA suggests states have the ability to use one of the rate schedules associated with the following:

   a. Federal Employees Health Benefit Plan Coverage (FEHBP Health Insurance Coverage);
   b. State Employee Health Benefit Coverage; or
   c. The Health Maintenance Organization (HMO) plan that has the largest insured commercial, non-Medicaid enrollment in the state.

V. Address variation in state billing practices. We recognize the important role of non-physician practitioners in providing care to patients and support their inclusion in the proposed rule. Due to state variation in reimbursement methods, however, there may be instances where these practitioners bill for services using their own provider number, not that of a PCP. Under the proposed rule, these practitioners would not be able to receive the payment increase. We suggest that CMS amend the rule to allow for state variation in the way all providers, whom CMS proposes are eligible for this payment increase, might bill.

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VI. **Assist States with Expanding PCP Enrollment.** Medicaid has historically been a program where "any willing provider" may participate, and as a result states may have varying levels of experience with reaching out to providers to encourage them to enroll in the Medicaid program. We encourage CMS to ensure that states have adequate support and technical assistance available so that their outreach and communication efforts to the provider communities affected are effective and achieve the goals of this initiative. For example, such technical assistance could be in the format of monthly or quarterly calls where state staff share ideas and solutions to issues they have encountered when trying to enroll PCPs in their Medicaid program.

VII. **Clarify how the enhanced matching will work in managed care arrangements.** In other programs with enhanced matching amounts, such as Money Follows the Person, confusion has arisen regarding how the enhanced match should be treated in calculating capitation rates. CMS should offer specific guidance to states on how the enhanced match should be accounted for in capitation rate setting and when submitting CMS 37 and 64 reports.

In conclusion, we again express our appreciation to CMS for working with stakeholders to effectively implement various ACA provisions.

We thank you for consideration of our recommendations, and we would be pleased to answer any questions you may have.

Sincerely,

[Signature]

Caroline Haarmann
Director, Medicaid Reimbursement & Research

cc: Cindy Mann
    Mary Cieslicki
    Linda Tavener