AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

June 6, 2012

The Honorable 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, CMS–2370–P

Dear Ms. Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 105,900 family physicians and medical students nationwide, I write in response to the proposed rule by the Centers for Medicare & Medicaid Services (CMS) on "Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program" as published in the May 11, 2012 *Federal Register*.

This proposal discusses implementation of Section 1202, "Payments to Primary Care Physicians" from the *Affordable Care Act.* This provision increases Medicaid payments for specified primary care services to Medicare levels for certain primary care physicians in 2013 and 2014. The law specifies that physicians with a specialty designation of "family medicine, general internal medicine, and pediatric medicine" qualify for purposes of this increased payment. This regulation also proposes updates to vaccine administration fee rates that have not been updated since the Vaccines for Children (VFC) program was established in 1994. The AAFP was pleased that the *Affordable Care Act* recognized the growing crisis in Medicaid beneficiaries' access to needed primary care services and the importance of supporting primary care payments as a step toward encouraging more medical students to choose primary care specialties. The AAFP is hopeful that access to primary medical care services becomes easier for Medicaid beneficiaries once this regulation is final and fully implemented.

Eligible Physicians and Providers

In the proposed rule, CMS says the agency is "particularly interested in ensuring that primary care physicians receive the benefit of the increased payment." The AAFP strongly supports this goal, especially considering that congressional intent is unmistakable based on the section's title. As such, the AAFP must disagree with the agency's proposal to allow sub-specialists to qualify for this increased

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payment. The inclusion of sub-specialty physicians is not the intent of Section 1202 and would only serve to perpetuate existing disparities in physician reimbursement policies.

In total, states will receive from the federal agency an estimated $11 billion in new funds over 2013 and 2014 to bolster their Medicaid primary care delivery systems. Since funding is temporary, the AAFP is concerned that including sub-specialists will add unwarranted costs. Unless Congress acts to extend this provision, a sudden return to disparate and inadequate payment for primary care services needed by Medicaid patients after 2014 will again threaten to restrict their access to such needed services. The AAFP encourages CMS to adhere more closely to the intent of the law and only qualify true primary care physicians for this increased payment.

To achieve the mutual goal of ensuring that Section 1202 is structured to provide payments to primary care physicians, the AAFP recommends that CMS, as a first step and in adherence to the *Affordable Care Act*, restrict qualification to physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. The AAFP recognizes that physician specialty alone does not necessarily define a primary care physician, as many internal medicine and family physicians work as hospitalists or in emergency rooms. Many sub-specialists also use their primary training designation in filing claims with CMS rather than their sub-specialty training designation. We, therefore, recognize that further verification is required to determine proper eligibility for these increased payments.

The AAFP is concerned that CMS proposes to use a claims-based process for identifying eligible physicians similar to the Medicare Primary Care Incentive Payment (PCIP). By proposing to do so, this regulation unnecessarily compounds a flaw in that process. Policy that uses E&M codes, nursing home, and home health claims to determine eligibility creates an unintended motivation for physicians to narrow their scope of practice. The Robert Graham Center, a division of AAFP that conducts research and analysis that brings a family practice perspective to health policy deliberations, reported that these policies exclude most rural primary care physicians and other physicians performing a broad scope of practice. While the Medicare PCIP eligibility is prescriptively detailed in legislative language, the Medicaid parity legislative language has no such restriction which allows CMS the flexibility to verify eligibility through more innovative techniques.

As a next step toward the appropriate identification of primary care physicians for purposes of this enhanced payment, the AAFP recommends that CMS use processes that identify the definitional elements of primary care, which include first contact, continuity, and comprehensiveness of care. Utilizing these key definitional elements of primary care will limit this payment to the appropriate physicians that are providing primary care. We provided greater detail regarding this approach in our March 12, 2012 letter to CMS concerning short- and long-term strategies for improving primary care payments. Taken as a whole, this method is highly predictive of physicians practicing primary care and creates proper motivation for primary care physicians to continue offering these services to Medicaid patients.

The AAFP recognizes that this approach is more complex than that proposed by CMS, but we believe it better captures a more functional definition of primary care, and thus more closely adheres to legislative intent. Since we recognize that this definition may appear more complicated than the approach CMS proposes in this regulation or used in conjunction with the

Medicare PCIP, the AAFP and Robert Graham Center staff remain willing to work with CMS to implement this suggestion.

If this new definition is too complicated for CMS to implement immediately, the AAFP would agree to the agency using the less sophisticated PCIP definition in the interim. That is to say, if the agency, for the purpose of determining eligibility for this additional payment, is not able before 2013 to identify qualifying primary care physicians based on the core definitional elements of primary care, then the AAFP urges CMS to limit qualification for the increased Medicaid payments to:

- Physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine that are Board certified; and to
- Physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine that, if non-Board certified, are providing at least 60 percent of Medicaid allowed charges by the eligible physician as Evaluation & Management (E&M) codes and vaccine administration codes. The AAFP supports the use of "allowed charges" rather than "billed codes" to increase consistency with the Medicare PCIP definition.

The AAFP does not believe Congress intended gastroenterologists, pediatric cardiologists or other subspecialists to receive payment as primary care physicians; therefore, we disagree with the proposal to include subspecialists related to the three primary care specialties designated in the statute. Of the three specialties referenced in Section 1202 of the *Affordable Care Act*, only board certification established by the American Board of Family Medicine requires physicians to maintain their basic level of certification in primary care. If CMS insists on extending these increased payments to sub-specialty physicians, then the AAFP strongly urges CMS to subject them to the "60 percent" threshold regardless of whether these physicians are or are not board certified.

The proposal discusses that "in Medicaid, many primary care physician services are actually furnished under the personal supervision of a physician by non-physician practitioners, such as nurse practitioners and physician assistants. Such services are billed under the supervising physician's program enrollment number and are treated in both Medicare and Medicaid as services of the supervising physician." Consistent with that treatment, CMS proposes that primary care services performed by a non-physician practitioner would be paid at the higher rates if properly billed under the provider number of a physician who is enrolled as one of the specified primary care specialists, whether furnished by the physician directly, or under the physician's personal supervision. The AAFP concurs with CMS on this approach.

Specified Primary Care Services

CMS proposes that Healthcare Common Procedure Coding System (HCPCS) E&M codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors would be eligible for higher payment. These codes are specified in the *Affordable Care Act* and include primary care E&M codes not reimbursed by Medicare. The AAFP concurs with the agency that the statute provides latitude to include codes not reimbursed by Medicare. Thus, the agency proposes also to include the following E&M codes as primary care services that are not reimbursed by Medicare:

- New Patient/Initial Comprehensive Preventive Medicine—codes 99381 - 99387;
- Established Patient/Periodic Comprehensive Preventive Medicine—codes 99391 - 99397;

- Counseling Risk Factor Reduction and Behavior Change Intervention—codes 99401 - 99404, 99408, 99409, 99411, 99412, 99420 and 99429;
- E&M/Non Face-to-Face physician service—codes 99441 - 99444.

The AAFP supports the inclusion of the above codes and, on the same basis, would recommend that the agency also include:

- Domiciliary, rest home, or home care plan oversight services (CPT codes 99339 - 99340)
- Anticoagulant management (CPT codes 99363-99364)
- Medical team conferences (CPT codes 99366-99367)
- Care plan oversight services (CPT codes 99374-99380)

All of these services have established RVUs. However, CMS does not pay for them separately under the Medicare physician fee schedule. CMS considers most of them “bundled" with other services paid under the fee schedule. While some of these services and corresponding codes ultimately would be part of a care management fee (as planned for in the Comprehensive Primary Care Initiative), the AAFP believes that paying for them going forward on a fee-for-service basis is a sound and interim short-term strategy. All are integral to primary care, and we note that the Relative Value Scale Update Committee (RUC) has made a similar recommendation to CMS.

CMS proposes that states be required to use the Medicare Physician Fee Schedule rate applicable to site of service and geographic location of the service at issue. For services unique to Medicaid for which relative value units (RVUs) have not been established by Medicare, CMS proposes to develop applicable RVUs in a separate fee schedule developed by CMS and issued prior to 2013 and 2014. The AAFP concurs with CMS on this approach and looks forward to working together with CMS to develop the applicable RVUs through rulemaking.

Updates to the Medicare Physician Fee Schedule

In the proposal, CMS recognizes the potential for multiple updates to the Medicare Physician Fee Schedule in 2013 and 2014 as rates published by CMS on or before November 1st of the preceding calendar year are often subject to periodic adjustments or updates throughout the year. CMS seeks comment on the proposal to permit states the option of either adopting annual rates or using a methodology to update rates to reflect changes made by Medicare throughout the year. Given that updates are complicated and conducted sporadically, the AAFP is concerned that allowing states the option to adjust their rates throughout the year would cause significant confusion and undue burden to medical professionals. The AAFP, therefore, supports adherence to rates published in the final fee schedule on an annual basis.

Federal Funding for Increased Payments for Vaccine Administration

The *Affordable Care Act* calls for an update to the interim regional maximum fees that providers may charge for the administration of pediatric vaccines to children who are eligible under the Vaccines for Children (VFC) program. The vaccine administration billing codes recognized for reimbursement under the statute are 90465, 90466, 90467, 90468, 90471, 90472, 90473 and 90474 or their successor codes. The final national average administration charge in 1994 was $15.09. According to CMS, no data is readily available on physician’s actual costs, so CMS proposes to use the Medicare Economic Index (MEI) to update the maximum administration fee based on the 1994 VFC value. Based on that approach, CMS determined that the updated national average administration charge would be $21.80.

To permit providers participating in the VFC program to benefit from the provisions of the *Affordable Care Act*, this rule proposes that states be required to reimburse VFC providers at the lesser of the 2013 and 2014 Medicare rates or the maximum regional VFC amount in those years. The AAFP supports this as a step in the right direction of supporting primary care physicians in their provision of this valuable public health service.

Conclusion
The AAFP appreciates that CMS recognizes that implementation of this rule is "necessary to promote access to primary care services in the Medicaid program before 2014." CMS further states, "primary care for any population is critical to ensuring continuity of care, as well as to providing necessary preventive care, which improves overall health and can reduce health care costs." The AAFP agrees with these sentiments and offer these comments in order to achieve these objectives. We make ourselves available for any questions you might have or clarifications you might need. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Roland A. Goertz, MD, MBA, FAAFP
Board Chair