ACP
American College of Physicians
internal medicine | Doctors for Adults

June 11, 2012

Marilyn Tavenner, Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8013
Baltimore, MD 21244–8013

Re: **Medicaid Program: Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccine for Childrens Program (CMS-2370P)**

Dear Administrator Tavenner,

The American College of Physicians (ACP) appreciates this opportunity to comment on the above referenced Proposed Rule. ACP is the largest medical specialty society and second largest physician membership organization in the United States, representing 132,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults and medical students who are considering a career in internal medicine.

The American College of Physicians has advocated for health insurance coverage for all for over the past two decades. The expansion of Medicaid coverage beginning in 2014 to individuals with earnings up to 133% of the federal poverty level through the Affordable Care Act of 2010 is a positive step towards this goal. It is estimated that approximately 16 million additional Americans will be covered under this federal program [1]—most being childless adults. This proposed rule recognizes that ready access to primary care services is a core goal of the Medicaid program, and attempts to ensure through increased payments that a sufficient number of primary care physicians and related specialists /subspecialists participate in the program to meet the needs of this expanded population. More specifically this proposed rule would implement Medicaid payment for primary care services furnished by primary care and related physicians in calendar years 2013 and 2014 at rates not less than the Medicare rates in effect in those years. The federal government would be responsible for the total cost of these added payments during this time period.

[1] Congressional Budget Office. Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act MARCH 2012. Accessed at http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf

The College is very supportive of the overall goal of this proposed rule and generally supports the specific regulations the rule defines. Below are a list of comments and recommendation for your consideration:

- **Definition of Physician Eligibility** --- The College commends CMS for the broad definition used in defining those physicians eligible for these increased payments. The definition includes primary care specialists (family medicine, internal medicine and pediatrics) and the subspecialists related to these primary care specialty areas through their respective certifying boards. It also qualifies those physicians that provide at least 60 % of codes billed from the set of defined primary care codes. The broad definition recognizes that the delivery of primary care services is not restricted to traditional primary care specialists, but is often provided by primary care subspecialists and other physicians.

  The importance of this broad definition of eligible primary care physicians cannot be over-emphasized. Research reflects that obtaining subspecialty care for both adults and children in Medicaid is problematic [2] [3] and is directly related to the reluctance of many primary care specialists to participate within the program [4] --- it is a barrier to the provision of quality care. These subspecialists, through consultation and co-management, are also an important part of the "team" of clinicians required to treat many common conditions within the Medicaid population (e.g. asthma, diabetes, heart problems). In addition, for those patients with severe and complex conditions, these subspecialists often provide the first-contact, comprehensive care required by this very vulnerable population.

  While ACP supports the alternative eligibility determination method based on the proportion of defined primary care services delivered by the physician, the College recommends that the 60 % criteria should be based on allowed charges rather than percent of billing codes—this would be consistent with the definition used under the Medicare Primary Care Bonus provision of the ACA and would be less likely to inappropriately exclude those physicians who truly provide primary care services, but are also required to provide a broad range of other services due to the limited availability of other clinicians in the area e.g. in rural and similar underserved areas.

- **Care Provided by a Non-Physician** --- The College also commends CMS for making the increased payment available for those designated primary care services provided by a non-physician practitioner (e.g. Nurse Practitioner) if properly billed through a qualified, supervising physician. This will serve as further incentive for physician participation in the Medicaid program.

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[2] Government Accountability Organization. MEDICAID AND CHIP Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care. June 2011. Accessed at http://www.gao.gov/products/GAO-11-624

[3] Kaiser Family Foundation. Health Reform Roundtables: Charting A Course Forward. May 2011. Accessed at http://www.kff.org/healthreform/upload/8187.pdf

[4] ibid

- **Primary Care Codes Eligible for Enhanced Payment ---** The rules states 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 codes. The rule further specifies that Medicaid will also pay at the enhanced rate for codes in that range not currently paid for under Medicare and indicates four such service areas that are:
    - New Patient/Initial Comprehensive Preventive Medicine--codes 99381 through 99387;
    - Established Patient/Periodic Comprehensive Preventive Medicine—codes 99391 through 99397;
    - Counseling Risk Factor Reduction and Behavior Change Intervention—codes 99401 through 99404, 99408, 99409, 99411, 99412, 99420 and 99429;
    - E&M/Non Face-to-Face physician Service--codes 99441 through 99444.

  The College would like to point out that in addition to the four code sets above, there are additional E/M codes in the defined eligible range that Medicare does not currently pay for and should be eligible for the higher Medicaid payment. The College believes that these additional codes are all important for the delivery of effective care and their payment would increase the likelihood of physician participation in the program. These are:

    - Consultation Services (99241-99245 and 99251-99255)
    - Anticoagulant Management (99363 and 99364)
    - Medical Team Conference (99366-99368)
    - Care Plan Oversight (99339-99340 and 99374-99380)
    - Counseling Services (99401-99420)

  The College would also like to point out that in the past several years Medicare has been paying for a number of preventive, counseling and screening services through "g" codes rather than the related E/M service codes. Many of these codes derive from recommendations from the U.S. Preventive Services Task Force. The College recommends that these services be included as eligible under the provisions of this rule. A list and description of these services is available at http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ .

- **Continued Barriers to Physician Participation within the Medicaid Program---** The limitation of enhanced payment for only two years will serve as a barrier for participation by many of our members—even at these enhanced rates. In addition, survey research indicates that there are substantial administrative hassles connected with physician participation within the program—these include onerous billing

requirements, unnecessary paper work and delayed reimbursement. [5] [6] In order to address these issues, ACP recommends that:

- CMS work with the states to facilitate timely data collection to determine the effects on the quality and efficiency of care being received under Medicaid with the implementation of these enhanced fees. The more evidence that can be obtained that this provision provides increased physician participation, improved care to beneficiaries and lower cost to the states, the more likely the states will cover this enhanced payment following the termination of this provision. We believe physicians would be more willing to participate if efforts were being made to increase the likelihood of these enhanced payments following 2014.
- CMS work with the states to reduce the administrative hassles on physicians who choose to participate in the Medicaid program.

The College appreciates this opportunity to comment on and provide recommendations regarding this proposed rule. Please direct any questions you may have regarding this letter to Neil Kirschner on our staff at nkirschner@acponline.org or 202 261-4535.

Respectfully

Robert Gluckman, MD, FACP
Chair, Medical Practice and Quality Committee

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[5] Cunningham PJ. May JH. Medicaid Patients Increasingly Concentrated Among Physicians. Tracking Report No. 16. Center for Studying Health System Change Aug. 2006. http://www.hschange.com/CONTENT/866/#ib10

[6] Cunningham PJ. O'Malley AS. Do reimbursement delays discourage Medicaid participation by physicians. Health Affairs 28(1), 2009 w17-28 accessed at http://content.healthaffairs.org/content/28/1/w17.full.pdf