National Association of Public Hospitals and Health Systems

1301 Pennsylvania Avenue, NW
Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax
www.naph.org

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

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

Dear Ms. Tavenner,

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to comment on the proposed rule to implement Section 1202 of the Health Care and Education Reconciliation Act of 2010 (HCERA), which would increase Medicaid payment rates for certain services provided by primary care physicians. As a representative of major providers of primary care to Medicaid patients and other vulnerable populations, NAPH strongly supports efforts to ensure that Medicaid payment rates are high enough to enable access for the Medicaid population, particularly given the expected surge in the demand for care due to the Medicaid coverage expansion in 2014.

NAPH represents major metropolitan-area safety net hospitals and health systems, which provide access to high-quality health care for all patients regardless of ability to pay. These hospitals and health systems are critical sources of care for low-income and vulnerable populations—about half of all the care provided by NAPH members is for Medicaid and uninsured patients. Medicaid continues to be the most important source of revenue for safety net hospitals, accounting for 35 percent of NAPH members' total net revenues.

In addition to providing significant amounts of inpatient services to vulnerable populations and critical trauma and emergency services to entire communities, safety net hospitals are leading providers of outpatient primary care. Along with their on-campus hospital clinics, many safety net hospital systems operate extensive networks of community clinics. These often freestanding health clinics serve as medical homes to residents in thousands of communities across the country. Safety net hospitals also utilize mobile units to deliver ambulatory care services to schools and housing developments.

In 2010, NAPH members saw more than 46 million non-emergency outpatient visits. Of the total amount of non-emergency outpatient visits provided by NAPH members in 2010, 55 percent—13.4 million uninsured visits and 12 million Medicaid visits—was for uninsured and Medicaid patients, reflecting the commitment of safety net hospitals to provide ambulatory care to low-income individuals and the chronically ill.

Because of their crucial role in providing access to high-quality care for Medicaid patients, safety net hospitals rely on adequate Medicaid payments. The following comments reflect NAPH's support of efforts to this end and suggestions for strengthening the proposed rule even further.

NAPH appreciates and supports the work done in the proposed rule to implement Section 1202 of HCERA. NAPH applauds the Centers for Medicare & Medicaid Services (CMS) for recognizing that higher payments to primary care physicians serving Medicaid patients will result in greater physician participation in the Medicaid program, thereby promoting overall access to care. NAPH strongly agrees that a vital link exists between adequate reimbursement for Medicaid providers and access to care for Medicaid beneficiaries. And this link becomes even more crucial as we approach the significant Medicaid coverage expansion in 2014. When Medicaid rates drop too low, many providers either cannot afford to or choose not to treat Medicaid patients. Those providers that do continue to treat Medicaid patients are often forced to shift the unreimbursed Medicaid costs onto other payers. While safety net providers will continue to serve the Medicaid population regardless, their ability to do so becomes severely compromised when they are compensated well below cost. In short, when the number or capacity of providers serving Medicaid patients is reduced due to inadequate Medicaid rates, beneficiaries' access to care is restricted, particularly as compared with the access to care available to the general population.

Adequate Medicaid funding is also critical to safety net providers' efforts to lead the development of accountable care organizations, patient-centered medical homes, and other delivery system reforms that provide high-quality, cost-effective care to low-income patients. NAPH members have worked with states on Medicaid waivers and other initiatives that have proven to be effective models for providing cost-effective care to low-income, uninsured patients, even at the current very low Medicaid reimbursement levels. Continued reductions in Medicaid funding, which many providers are facing due to state budget pressures, make it difficult for these providers to continue to serve uninsured patients. The primary care payment increase will help providers continue their progress toward effectively managing low-income and uninsured patient care without disruption until Medicaid helps to assume these costs in 2014.

Finally, implementing this proposed rule will provide for increased federal financial participation (FFP) in Medicaid cost-sharing for Medicare/Medicaid dual eligibles. As CMS notes, Medicare pays 80 percent of its fee schedule rate for services, while Medicaid pays the remaining costs. States can choose either to pay providers up to the full Medicare cost-sharing amount or only the amount necessary to ensure that the aggregate payment is equal to the state's Medicaid rate—which often results in no Medicaid payments, because the Medicaid rate is lower than 80 percent of the Medicare fee schedule. While the Medicaid primary care payment increase is in effect in calendar years 2013 and 2014, the Medicaid rate should equal the Medicare rate for primary care

services, and thus providers should receive the full Medicare cost-sharing amount. **Given the importance of managing care and ensuring access for vulnerable patients, including dual eligibles, and supporting providers as they work to build the capacity to care for an increased number of Medicaid patients, CMS should finalize its proposal to implement this primary care payment increase.**

However, as CMS moves forward with finalizing this rule, the agency should consider the following clarifications and revisions to the proposed rule, which would make the payments as beneficial as possible in strengthening the primary care workforce and ensuring access to care for the Medicaid population.

NAPH supports the broad scope of primary care providers and services eligible for the primary care payment rate increase, including mid-level practitioners. In the proposed rule, CMS notes that many primary care services are provided under the supervision of physician and nonphysician practitioners, such as nurse practitioners and physician assistants. CMS also acknowledges the critical differences between the Medicare and Medicaid programs by including service codes in the proposed rule that are not part of the Medicare physician fee schedule, but are critical services for the diverse Medicaid population. NAPH members are increasingly looking to boost workforce efficiency, and thus access, through programs that support the use of physician extenders. NAPH members also work to provide the full range of services to Medicaid patients, who have complex medical needs. **To support these critical safety net goals, CMS should finalize these aspects of the proposed rule that allow a broad group of primary care providers to receive the payment rate increase and CMS should give states the flexibility to designate additional primary care service codes beyond the ones included in the proposed rule.**

NAPH supports CMS' efforts to ensure primary care providers receive the benefit of the rate increase, whether under fee-for-service (FFS) or managed care plans. The proposed rule requires states to pay Medicare rates for both FFS and managed care patients. Managed care organizations (MCOs) are required to pay their primary care providers Medicare-level rates for primary care services, and states are required to increase the capitation rate paid to MCOs (funded with 100 percent federal funds) in order to account for the higher payment. NAPH appreciates CMS' recognition that providers serving Medicaid managed care patients may not see the benefit of the increased capitation rates without some oversight by CMS and applauds the inclusion of language addressing this issue. **CMS should finalize the proposed rule's language enforcing managed care contracts and Medicaid state plans to comply with this requirement while limiting—to the extent possible—the reporting burden of doing so.**

However, CMS should clarify the payment rate for certain state programs that, as of July 1, 2009, may have included supplemental payments up to the Medicare rate on the FFS side but have not extended it to physicians caring for Medicaid managed care patients. In many cases, states created supplemental payments as part of their FFS programs but were prohibited by Medicaid rules from making similar payments for managed care patients (i.e., the direct pay prohibition at 42 C.F.R. §438.60). Those states likely did not factor those supplemental payment amounts into their calculation of MCO capitation rates. Even in the unlikely case that they did adjust the capitation rates, there would have been no provision in place to ensure the benefit

reached primary care providers. To ensure primary care providers receive the support necessary to provide access for Medicaid patients, **in the final rule CMS should clarify that these states should include payment increases up to the Medicare rate in their capitation payments, even if no corresponding payment increases are required for FFS patients, and modify their state plans and contracts with MCOs accordingly.**

CMS should amend the proposed calculation of Medicare payment rates to include the Medicare primary care incentive rates in Section 5501(a) of the Affordable Care Act (ACA). CMS states in the preamble to the proposed rule that Section 5501(a) of the ACA provides for Medicare primary care incentive payments for a subset of the codes covered by the proposed rule. However, CMS concludes that the Medicare incentive payments are not made as increases in fee schedule amounts, and therefore states cannot include them when calculating what Medicare would have paid for the services. CMS' conclusion is inconsistent with the language of HCERA. Section 1202 requires states to pay "not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII" (which is the law governing Medicare). The ACA added the Medicare primary care incentive payments to section 1833 of the Social Security Act, which defines "Payment of Benefits" under part B of title XVIII. Under this construction, the Medicare primary care incentive payments are part of the "rate that applies to such services and physician under part B of title XVIII." Since Congress determined when passing the ACA that Medicare rates should be increased to support access to Medicare primary care services, and Medicaid rates should in turn be increased to what Medicare would pay, Medicaid rates should not be less than an amount deemed necessary for adequate access for Medicare patients.

Finally, as CMS continues to implement changes to the Medicaid program and other health reforms, the agency should assess Medicaid patients' access to the full range of critical Medicaid services and address any deficiencies through other regulatory avenues. Well-documented studies have described the consequences of a national shortage of specialty care available to uninsured and low-income individuals. Long waits for specialty visits, or an inability to access care at all, have been shown to result in poorer health outcomes and greater use of ED and inpatient services.[1]

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[1] L.E. Felland, S. Felt-Lisk, M. McHugh, *Health Care Access For Low-income People: Significant Safety Net Gaps Remain.* Issue Brief No. 84, (Washington, DC: Center for Studying Health System Change, June 2004); M. Regenstein, L. Nolan, M. Wilson, H. Mead, B. Siegel, *Walking a Tightrope: The State of the Safety Net in 10 U.S. Communities,* (Washington, DC: Urgent Matters, The George Washington University Medical Center, 2004); J. Graham, "Needy Patients Find Door Shut When Searching for Specialist," *Chicago Tribune,* May 23, 2005.

NAPH appreciates the opportunity to submit these comments and looks forward to working with the agency as CMS continues to address the challenges of adequate payment rates and related access issues in the Medicaid program. If you have any questions, please contact Xiaoyi Huang, assistant vice president for policy, at 202-585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and Chief Executive Officer
NAPH